

# Psychotherapy

and

# Ubuntu

Therapeutic meetings in a South African context

by

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## **ABSTRACT**

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The purpose of this study was to explore therapeutic meetings in a South African context. Utilising a qualitative research method, I have examined how South African therapists work in a multicultural context, asking questions regarding challenges the therapists met, what elements existed in the African context that influence healing. I proposed that the concept of Ubuntu could provide an African perspective to balance the western notion of psychotherapy. I also explored what adjustments therapists made in order to make psychotherapy more applicable to the South African context and whether it was possible to create identification and recognition in a cross-cultural therapy, investigating whether there can be created a room for healing, or the psychoanalytic notion of “thirdness” when therapist and client do not share the same cultural background. My sample consisted of 9 South African therapists, and the group was representative of the diversity of South African society.

The findings supported the assumption that South African psychotherapists meet extensive challenges in their practices. These were challenges both to the initiation and sustaining of a therapeutic process, such as poverty, stigma and language, and to the therapeutic work itself. My informants said they made modifications to the psychotherapeutic model, but struggled to define specifically what they did. All my informants felt the need for more African based psychotherapy theory, and believed the notion of Ubuntu could be one way to bring in an African perspective. However, the majority did not believe integrating traditional forms of healing into psychotherapy was the *modus operandi* to achieve such theory. Findings further supported the assumption that thirdness could be created in a cross-cultural therapeutic meeting provided the opportunity was given to addressing difference and transcend culture through recognising it.

## PREFACE

This thesis has come out of a long personal journey. Although I started working on the project itself as late as 2004, the desire to find a way to approach the topic has been deep-seated in me long before I started pursuing a profession of therapeutic work. It comes from living a life carrying more than one culture and thinking around the best ways to do so.

South Africa and her unique history inspired me, touched me and gave me hope for other countries struggling with racial and other forms of prejudice. As a young girl, I read the book “Skindeep” by Toeckey Jones. It tells the story of two people falling in love in South Africa during the reign of apartheid. One is white and the other one looks to be. But it turns out he is what was called “paperwhite”; he has a skincolour light enough to be classified as white, but his parents are actually what was labelled “coloured” in South Africa, that is of “mixed” race. When racial prejudice is part of national law, two people of different races cannot live together. This was the South African reality for decades. And yet, having lived this brutal reality, the people of South Africa still managed to find a peaceful way of acquiring freedom.

My first actual meeting with South Africa came in 2004, on the 10<sup>th</sup> anniversary of the abolition of apartheid. I was intrigued by the transition from rigid segregation to what Desmond Tutu has called “the rainbow nation”, the work of the Truth and Reconciliation Commission and the therapeutic challenge of healing the wounds of apartheid. Being there at that specific moment in time gave me the impetus for taking on the overwhelming, difficult and more than a little delicate task this thesis promised to be.

I would like, first and foremost to thank my supervisor Fanny Duckert for entrusting me with the ability to pull this off. She believed in me right from the start and has been there through the times that I thought I might have to give it up. My co-supervisor Nomfundo Walaza for taking the time to guide my data-collection period, for establishing contact with my informants and for sharing with me her insights and knowledge. I would like to thank my informants for being so genuine and for daring to undertake the sometimes brutally honest self-reflections they made during our interviewsessions. In sharing with me their struggles and vulnerabilities, their skills and experiences, they have given me an invaluable pool of information and an opportunity to take part in what goes on behind doors of therapy rooms in South Africa. Sahieer Parker made an invaluable effort to secure otherwise non-available African psychotherapy literature for me and I am extremely grateful; an acknowledgement also to Tormod Berg for providing access to literature in Norway. A warm thank you to Dan Vaughan, former CEO of the Desmond Tutu Peace Centre where I worked during my datacollection period – his care and support means so much to me, and to Father Tutu himself for being the truly great inspiration that he is, and for the morning sermons that I carry with me.

To Yosef for sharing his South Africa with me, to Nicolay and Peder for sharing their psychology with me, to my mother for always being there for me and to Oskar for everything.

## Ubuntu

*“It is **everything** that is good about a human being. This person is generous...you know, when we really want to praise somebody we say: “Shyo! U nobuntu”: “Wow! This person has got Ubuntu”. Because maybe you were passing by on the street and it’s a **hot** day, and you were struggling. And the person says: “please come here, here is a cup of cold water”, you know...that kind of generosity which...in a way almost sees oneself in the other. And basically of course, it says: “I can’t exist without you”. It’s an impossibility. Well it is, for one thing, a biological impossibility. Two other human beings have got to come together in order for a new individual to come into existence. That is how utterly dependent we are of one another. I mean, you as a psychologist **know** that a baby, if she were to be left alone with no interaction between her and another human being, she would not know how to speak a language or think as a human being because we **learn** how to become human, and we learn that from other human beings. I need you to be you if I am going ever to be me. I can’t be me without you being you (...) And we’re **so** utterly dependent on others that if at an early age we did not experience loving and caring – we are scarred for life. When we say “The hand that rocks the cradle, rules the world”, it seems such a wild and sentimental statement. But it’s true. There’s an incredible kind of interconnectedness”*

(Archbishop Emeritus Desmond Tutu, personal interview)

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# 1. INTRODUCTION

## 1.1. Introduction

As I set out to write this thesis, I had some fundamental questions I wanted answered. These questions originate from two parts of my personal experience: one is my private experience of growing up juggling to integrate two cultures in one person and creating an identity incorporating both. The other is my journey towards becoming a clinical psychologist, still juggling my two cultures and creating a professional identity incorporating both. I realised that my two cultures were a blessing rather than a curse in a professional setting, because students and therapists often confided in me their apprehensions about entering a therapeutic relation with a client from a different cultural background. They had questions: “How can I create a sense of identification with this person?” and insecurities: “I think she can see that I do not understand her” And the most frustrating question of them all: why is there no place I can go to find out how to do this? Progressing through my clinical training, some of their questions became mine, gradually realising psychotherapy had not yet addressed its own cultural identity, its “culturality”.

Psychotherapy, or “the talking cure”, was an idea that grew out of one man’s belief that pains of the mind could be the cause of pains of the body. From this belief grew the field of clinical psychology or psychotherapy. These ideas, however, were developed in a specific cultural context. Does this westernly originated theory of healing also yield results in a broad spectrum of cultural contexts? Psychology claims to deal with matters of the universally human. One of the underpinnings of the idea of a talking cure is that there exists a certain something that all humans recognise. But is it so? Is it true, instead, that what culture we are born into makes the way we experience emotion, how we relate to people, what we need to heal different? And if so, how does this affect psychotherapy? If therapist and client bring in different worldviews, can a sense of identification be created? What in intersubjective and relational psychoanalytic tradition is labelled “thirdness”, can this state of mutual understanding be created traversing the canyon that culture sometimes represents, so that therapist and client together can initiate a process of healing? And if so, how does one go about doing this? Can one utilise the tool that is psychotherapy within its original framework, or does one need to make certain adjustments to reach the same space of understanding? I wanted to explore the therapeutic meeting set in a South African context in order to inform these questions. South Africa has a history of racial segregation and subsequent integration

that gives therapists working in this context a unique experience from which one can draw invaluable insight.

I entered into this investigation carrying a particular perspective on therapy and a theoretical stance. My grounding as a therapist lies within the psychodynamic/psychoanalytic school, and more specifically with the intersubjective/relational approach. This implied that while being multicultural, as a professional, I carried the ideology of this therapeutic school. Generally, one could say that psychotherapy as a discipline, carries with it a philosophy. Mitchell and Black (1995) argued that

*“Today, Freud’s contributions are so broadly accepted, so tightly woven into the fabric of our culture, that, in the broadest sense, we are all “Freudians”. Psychoanalysis is not only a professional and scientific discipline **within** our culture, but a form of thought, an approach to human experience, that has become **constitutive** of our culture and pervades the way we have come to experience ourselves and our mind (pp. xviii-xix)”*

Our culture has formed its own idioms of expression that are closely linked to and easily understood within the psychotherapeutic framework. There are certain taken-for-granted presuppositions about what is the “universal” worldview. What happens when a client does not hold these same presuppositions to be true? One would still wish to create that room for healing and one way to do this was to allow for a different cultural perspective.

Being set in a South African therapeutic context, this thesis sought to offer an African perspective on psychotherapy. One aspect that characterizes the cultures of Africa is their sense of interconnectedness and interdependence. In South Africa, this understanding is called Ubuntu. (Lane, 2000) and has been closely connected to one person, Archbishop Desmond Tutu. He has explained that Ubuntu represents the notion that a person is a person through other persons. (Tutu, 1999; Gylseth, 2006). Through his voice, Ubuntu has been seen as a symbol of forgiveness and transition from apartheid to democracy. African humanism has also been described in various African countries, hence Ubuntu was found to be a valid and representative perspective to introduce when exploring psychotherapy’s applicability to people of African cultural descent.

## **1.2 Thesis Background**

This thesis originated as a response to the observation of a specific need in the field of psychotherapy in Norway: the need to address the changing working arena for practicing psychotherapists. Being in the “globalisation era” (Duckert&Lie, 2006) entails taking part in a rapidly changing world and being exposed to fellow human beings from more distant parts of this globe. As a consequence Norwegian society has changed. Immigrants and refugees have long since turned this country into something very different from what it was merely 20 years

ago. And as culture is dynamic in nature, Norway is continuing to change, further evolving into a multiethnic, multicultural country. This requires us to take a critical look at our tool for healing and how we as therapists apply this tool.

### ***South Africa as a comparative***

There were very explicit reasons for me choosing South Africa specifically as a comparative for my study. I believed that the country's history provided a unique observation ground for western countries experiencing immigration<sup>1</sup>. Having spent years enhancing and idealising differences, the 14 years since the abolition of apartheid were spent trying to reintegrate and co-exist. Living with prejudice and racism systemised and incorporated into national law made South Africa a very racially and culturally *aware* society. This led me to believe that the dialogue in South Africa had much to teach Norwegian thinking around cross-culture and psychotherapy. South Africa is an example both of how psychology can be used and abused to build and maintain a society of inequality, abuse and minority rule. (Bulhan, 1985, Sveaass, 2005) Earlier dissertations written by clinical psychology students have focused on psychotherapy's applicability to people of African cultural descent, and one specifically on South African therapists and indigenous healing. (Michalopoulos, 2001). The focus, however, has been on black therapists working in rural areas, seeing primarily black clients and applying western psychotherapy in this context.

My focus was slightly different and lead to another investigation: I wanted to explore psychotherapy in a multicultural setting, where both therapist and client carried more than one identity. I believed this a more appropriate reflection of the current clinical setting in many parts of the world, including Norway.

### **1.3 Research purpose**

My overarching topic of investigation was to examine if there are any unifying elements in therapy that operate across cultures. If psychotherapy indeed held the power to heal across cultures. My belief was that therapeutic healing was created through the relationship between client and therapist. What does this relationship look like if client and therapist come from different cultures? I wanted to find out whether one could lift a therapeutic meeting to a metalevel where healing was attained and culturebarriers overcome. My vision of such a meeting was of a co-created reality. In psychoanalytic literature, such a space has been described as "thirdness" (Binder, 2006; Benjamin, 2004, Ogden, 1994; 2004, Greene, 2004;

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<sup>1</sup> See appendix for an outline of South African history and facts



Hanley, 2004, Binder et al, 2006). Is thirdness attainable in cross cultural therapy? To inform my overarching topic of investigation, I asked the following research questions:

1. What challenges do therapists schooled in western psychotherapy meet working in a South African context?
2. What elements exist in African culture which influence therapeutic work?
3. What adjustments and modifications do South African therapists make in order to create a psychotherapy better suited for the South African context?
4. Is it possible to create a sense of identification between a therapist and a client of different cultural backgrounds and lift the therapeutic meeting to a level that transcends culture, thus creating a space for healing?

The first question addressed psychotherapy's "culturality" and how my informants related to working with this model. It also concentrated on the challenges they face in doing this and what barriers exist to attain healing. The second question addressed what elements particular to African culture existed to facilitate, impinge or disrupt psychotherapeutic work, and how the balance of these elements could help inform a development of an African psychotherapy. The third question dealt with what modifications were made to make psychotherapy more applicable to the South African context. The last question touched on the debate of whether there existed a psychic unity, and whether one can find this in cross-cultural therapy. It also touched upon the question of whether therapist and client could create and surrender to an intersubjective space, where both felt that they were co-creating reality. This was, ultimately, the question of whether thirdness was attainable in cross-cultural therapy.

#### **1.4 Background information South Africa**

South Africa today, is known as the "rainbow nation" with its over 47-million people of diverse origins, cultures, languages and beliefs. During the decades of the apartheid era, these peoples were forced to live separately and were grouped according to race. In 1985 Bulhan wrote:

*"There is perhaps no society in the world today that better illustrates the result of a violent compartmentalisation of people into races and the calculated fortification of a Manichean psychology. South Africa is a country in which the ruling authority relentlessly strives to divide its population into, as it were, four distinct "species" differentiated on the basis of race(...). Apartheid is indeed structural violence in its crudest form." (p.166).*

Race was closely connected to skin colour in apartheid South Africa, which provided a structured classification system. According to various types of assessments, the people of South Africa were classified into one of the following categories: Whites, Asian, Coloureds or

Blacks<sup>2</sup>. Individuals enjoyed rights according to race, and apartheid legislation forbid mixed marriages and sexual relationships across the racial classes (The Sexual Offences Act, also known as the “Immorality Act”). The “Blacks” was the racial group that suffered most under the apartheid system. The “homelands” or “Bantustans” were legislated through successive land acts. Bulhan compared the Bantustans to concentration camps. All “Blacks” were stripped of rights to South African citizenship and classified as “citizens” of one of the different homelands (Ibid). All “Blacks” over the age of 16 had to carry, at all times, a “pass” or “reference book”, and the police or any government official could stop a person classified as “Black” at any time, anywhere asking for this pass. In conclusion, the apartheid system was set in motion to enhance the wealth and well being of whites at the expense of the rest of the South African population.

#### ***1.4.1 “Race”***

The concept of race is a problematic one. It stems from the phenotypical differences between human groups living in different parts of the world. Berry et al (2002) argue that behavioural and social sciences often refuse to recognise the notion of human races. However, what people believe to be true about race matters; racial beliefs have often sustained racism, the manifestations of which range from polite tolerance through mutual avoidance to genocide; or in the South African context, apartheid. Berry et al (2002) acknowledge that dispelling the notion of race, would not by itself put an end to racism, but they underline that the truth about race needs to be inserted into the efforts to combat racism. That truth, confirmed by the human genome project, is that our species comprises only one race: the human race. (p.265). But for the purposes of this thesis, I will use the term “race” according to the categorisations applied during apartheid rule, as this was also how the therapists in my sample referred to the notion of race. It should also be mentioned that individuals classified as Asian or Coloureds, often choose to refer to themselves as black in post-apartheid South Africa. This has led to the term “African black” being applied to specify the group of people previously categorised as Blacks.

#### ***1.4.2 Psychology and apartheid***

To provide a comprehensible presentation of challenges to present day psychotherapists, a brief history of psychology in South Africa will be presented.<sup>3</sup> Historically, South African psychotherapy has been largely the preserve of the privileged class, particularly whites. It was

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<sup>2</sup> See “Race” section for a discussion of the use of racial categories.

<sup>3</sup> See appendix for an outline of South African facts and history

taught in philosophy departments until 1918 when the first psychology department was constituted at the University of Stellenbosch. (Lockhat, 2004). Psychologists and researchers were aware of differences and problems related to the multiracial society South Africa already had become at the time. However, it was the focus on the “poor white problem” and the establishment of the Carnegie commission to address this problem, which allowed psychologists to demonstrate their skills at solving societal problems (Sveaas, 2005; Lockhat, 2004). This investigation provided the impetus for bringing psychological skills and techniques to public awareness. (Lockhat, 2004). The South African Psychological Association (SAPA) was established in 1948, and by way of error there was an omission of a clause in its constitution excluding other races from membership. Once black psychologists started applying for membership, it initiated a 5 year long debate where black psychologists were barred from participating. Eventually, however, it was agreed that blacks could be admitted, sparking fury among the white psychologists. They appealed to the government for legislation to hinder black membership. With the Group Areas Act of 1957, the law relating to the establishment of group areas and the control of the acquisition of immovable properties in those areas was consolidated, and through this, black psychologist membership was no longer a problem, as they were not allowed to enter the “all Whites areas”( SouthAfrica.info, 2008). In 1962, the Psychological Institute of the Republic of South Africa (PIRSA) was formed, this time exclusively white. During apartheid rule, the majority of psychologists chose not to combat the increasingly controlling, violent and unjust apartheid rule. Clinicians were attempting to convey a politically neutral and objective stance, primarily due to concerns of international censure. Instead of utilising professional knowledge and skills to promote equity, relieve pain and suffering, and counter-argue apartheid reasoning, many psychologists chose to help provide scientific bases for the notion of separate development (Lockhat, 2004). In conclusion, psychological knowledge was systematically utilised to uphold an oppressive regime, but being a profession including the scientific study of human behaviour, it was also used to give the apartheid regime psychological and scientific legitimacy (Sveaass, 2005). In the psychological profession as well as in South African society in general, it has been a “long walk to freedom” (Mandela, 1994). Murray (2002) quoted Cheryl de la Rey, editor of the South African Journal of psychology saying that psychology was not where it needed to be in South Africa post-apartheid due to the fact that it had been trapped within the service of apartheid and intentionally underdeveloped. Also, due to both apartheid rule and international sanctions, it was isolated from the international psychological discourse (Ibid). Having painted this grim picture of the profession however, in relation to this thesis, it is of relevance

to mention that within my informant group there were therapists trained during apartheid rule who worked relentlessly against apartheid and its violence and humiliation.

### ***1.4.3 Post-apartheid development***

The advent of a liberal constitutional democracy in 1994, as well as greater public awareness and education, facilitated access to “the talking cure” which has become more relied on, especially among upper-working-class blacks. (Cooper, 2007). However, the black-white ratio in psychology was almost the inverse of the racial representation in South African society. According to the last census, whites constitute less than 10% of the South African population but more than 80% of licensed psychologists (Nicholas & Cooper, 2001, in Cooper, 2007). Additionally, according to Murray (2002), the total number of psychologists in South Africa was around 5000 relative to the country’s population of 47.9 million<sup>4</sup> (SouthAfrica.info, 2008), leaving a dismal therapist-client ratio, and an even more problematic situation with regards to the availability of black psychologists. There are 11 official languages in South Africa: Afrikaans, English, isiNdebele, isiXhosa, isiZulu, Sepedi, Sesotho, Setswana, siSwati, Tshivenda and Xitsonga. Nine of the country's 11 official languages are African. During the apartheid era, translators were often used, without regard for ethics and efficacy. Cooper stated that most African blacks have had little access to culturally appropriate services post-apartheid, and that in nonurban areas “there are currently no psychological services” (Pillay, 2003, Pillay et al., 2004, in Cooper, 2007). The profession is governed by statutory boards or councils, and it is illegal to call oneself a psychologist without being so registered after earning a master’s and annually license to practice (Cooper, 2007).

This thesis consists of four sections. Following this introductory section, the second section is further divided into two subsections and will give a presentation of the relevant theoretical background; the first subsection will consider theories of cultural psychotherapy, African contributions to psychotherapy and the philosophy of Ubuntu. Next is a section on theories on thirdness in therapy. The section on methodology proceeds, before the analysis and discussion.

## **2. THEORETICAL PERSPECTIVES**

### **2.1 Psychotherapy and culture**

What exactly is culture? Vontress (2002) has defined it as “a group’s way of life” (p.1) that is passed from one generation to the next. He claimed it is visible and invisible, cognitive and

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<sup>4</sup> See appendix for facts and history of South Africa.

affective, conscious and unconscious and that it has universal, ecological, national, regional and racio-ethnic tributaries. Duckert and Lie (2006) quote Frank&Gomez-Dante in saying that globalisation is the “death of distance”. One of the most cited articles in cross-cultural literature is Matsumoto (1997, in Matsumoto, 2002) saying that culture is dynamic. How, in this era of globalisation can one speak of people as “monocultural”? Do we not all get influences every day from an enhanced level of communication from cultures very different from our own? Berry et al (2002), using the term unicultural, have argued that there is no contemporary society in which one culture, one language, one religion and one single identity characterises the whole population.

Approaching the topic from a perspective of psychotherapy, Sam (2006) argued that traditionally, the study of psychotherapy has assumed the existence of a “gold standard”, the “right way” to be human. This has become a standard for measuring human behaviour across the globe, though developed by observing and theorising on how a small group of westerners behaved. People differ culturally; hence it may be harmful to indiscriminately impose someone else’s way of behaviour on others (Ibid). We enter the arena of cross-cultural psychology. The field of cross-cultural psychology has generally been divided into two related domains: the cultural domain and the ethnic domain (Berry et al 2002). Sam (2006) explained that the aim in the cultural domain has been to understand how culture factors influence human behaviour. The objective has been to understand individuals being studied in their indigenous contexts, hence the arena of exploration is international. The ethnic domain, however, is concerned with how individuals acculturate, how they adapt to new cultural settings they meet as the result of a migration. The research arena in this domain, is the domestic one, the multicultural society. Research will also focus on the persistence of the culture of origin these individuals bring with them in the form of ethnicity.

This exploration incorporated the cultural domain and the ethnic domain. The investigation was conducted internationally in the sense that a Norwegian researcher has studied South African therapists. However, it was also an investigation of a domestic nature, exploring ethnicity in a multicultural society. In accordance with the position that findings derived from the international domain should inform the domestic domain (Sam, 2006), this exploration also sought insight applicable to the Norwegian context. In the following, Sam’s theoretical positions on how human behaviour is to be understood within the cultural domain will be presented and subsequently a brief presentation of the concept of acculturation will be given.

#### ***The cultural domain:***

The theoretical positions of the cultural domain are concerned with how human behaviour should be understood. The central question, according to Sam, was whether in explaining psychological processes one assumed the existence of a psychic unity and commonalities in psychological makeup, human experience and behaviour, or so called psychological universals, or whether it was presumed that behaviour can be best understood in the context in which it occurs. Sam has developed these two broader perspectives into four competing perspectives of psychological inquiry: *human uniqueness*, *absolutism*, *relativism* and *universalism*.

Sam (2006) argued that the perspective of *human uniqueness* might be incompatible with science, focusing entirely on the uniqueness of individuals, and assuming the search for commonalities in human behaviour and cultural context to be irrelevant. Though maybe limited for scientific purposes, Sam suggested this would be a position taken by an existential psychologist. The perspective of *absolutism* has assumed a golden standard. The mainstream orientation in modern psychology would fall into this category. Berry et al (2002) argued this position holds an assumption of the possibility for absolute truths, hence the label absolutism. It rests on the principle of psychic unity, the presumption that in eliminating culture and environmental factors such as norms, values and ideologies, one would be able to unveil the true human psyche. This position has argued that all human behaviour is the same regardless of where it is studied, and is just masked by variations in language. Culture would in this position be considered to be such a masking. One danger when taking this perspective, would be the risks of making ethnocentric conclusions. Berry et al (2002) define ethnocentrism in psychology to be “us better-them worse” (p.8), that is, when conducting cross-cultural research, one views differences as deficiencies, placing ingroup standards at the top of a hierarchy ranking all others as lower. *Relativism* on the other hand has sought to avoid all traces of ethnocentrism by trying to understand people in their own terms without holding any value judgements or a priori judgements of any kind (Sam, 2006). This position has avoided comparative studies, seeing them as problematic and ethnocentric. Explanations of psychological variations are to be sought in terms of cultural variations, and differences are explained as due to cultural contexts influencing an individual’s development. There is not much interest in the existence of similarities in the relativist position. *Universalism* has been concerned with the dynamic interaction between human beings and their environment, seeing basic psychological processes as likely to be common features of human life everywhere. Their manifestations however, are presumably influenced by culture (Sam, 2006). One adheres to the belief of an existing psychic unity, seeing variations in human behaviour such

as culture as contributors to different manifestations of common themes. While all the theoretical orientations may have their adherents, Sam argued that working in culturally plural societies, a relativist and/or universalist position would be required, as these two perspectives acknowledge the importance of culture in the expression of human behaviour.

### ***The ethnic domain:***

The ethnic domain has focused on the behaviours of culturally distinct groups and individuals living in plural societies. Berry et al (2002) defined culturally plural societies to be where a number of different groups reside together within a shared social and political framework (p.346). Sam (2006) claimed work in the ethnic domain did not differ in principle from work in the cultural domain. However, contact and possible conflict between cultural groups would be an added element. In terms of psychotherapeutic work, there is one important aspect to be underlined: when a health professional does not understand an individual's health needs while practicing in another country, the individual may have a recourse to an indigenous health system, in the ethnic domain there may be no such alternative. Sam and Berry both apply the concept of acculturation to describe the process individuals undergo in response to a changing cultural context. Derived from anthropology, this concept refers to changes occurring when individuals and groups of different cultural background come together. More often than not, this concept has been referred to when describing processes between immigrants and the host population. The integration in process in post-apartheid Africa does not come from immigration or people bringing foreign cultures with them to a new context. However, they are reshaping a way of co-existing and one could argue it to be a form of acculturation process.

#### ***2.1.1 Psychotherapy in Africa***

Peltzer (1999) has said that psychotherapy may appear to be a luxury in African countries. However, psychological disorders are increasing and are similarly frequent in African countries as in industrial nations, amounting to one fifth of all contacts in the general health services. The African continent has only recently begun to be included in therapy research (Cooper, 2007). Madu (2003) has presented an outline of psychotherapy in Africa, past and present and listed challenges for the future. He considered the past to be pre-1970, arguing that this was the era before and during the colonial days for many African countries. The area of mental health has to a large extent been handled by traditional healers, chiefs, and extended family in this period (Madu, 2003). Western oriented medicine and western formal psychotherapy was rarely found (Ibid). Traditional healers' approach to health is holistic

(Lesolang-Pitje 2003), involving ancestors, the king, the community and the client. Healers were seen not only as curers, but as in contact with the spirits, and as middlemen or mediators between the gods, spirits and humans (Ibid).

In the years Madu (2003) referred to as “the present”, from 1970 to the millennium, he argued that in Africa in general, over 80% of psychiatric and emotional problems were still brought to traditional healers. Christian religious faith healing also had a strong position in Africa, and modern medicine gained solid ground. However, other paramedical fields like psychotherapy, were still struggling to gain their ground (Mariach, 2003, Madu, 2003; Cooper, 2007). Madu believed there was a need to address the activities of traditional healers from a psychotherapeutic viewpoint, claiming that psychotherapeutic activity in Africa had not been sufficiently and efficiently documented and published. Many of my informants also characterised this as a weakness. Some therapists have attempted to develop African based forms of psychotherapy. Madu (2003) listed Ebigbo’s “Harmony restoration therapy” and Awaritefe’s “Meseron therapy”, developed in accordance with the Nigerian belief systems. Nefale & Van Dyk’s (2003) Ubuntu therapy, attempts to integrate the philosophy of Ubuntu and psychotherapy. Madu (2003) listed various challenges for the future, among them studying western oriented forms of psychotherapy, so as to be able to bring out the universal principles of human behaviour involved in them for application in Africa, while the aspects of western cultures inherent in these models would be replaced by corresponding aspects of African cultures. Related to this challenge would be increasing the efforts of developing new African forms of psychotherapy, separating the “in-Africa-originated” (p.141) principles of human behaviour in them from their cultural envelope, making these forms of psychotherapy applicable to other cultures. Madu also suggested strengthening the relational bond between African psychotherapists and their colleagues around the world, intensifying research in the area of psychotherapy and other healing activities to share with the world (Madu, 2003). He underlined that western trained psychotherapists have much to learn from those healing activities for the benefit of their African clients.

### ***2.1.2 Africans in Africa, rural versus urban areas***

As discussed previously, research acknowledges the dynamic nature of culture. In many of the African countries, this “dynamic nature” has been imposed, rather than chosen, by the process of colonization. However, voluntary or not, these countries have been affected by colonization and the cultures have become diluted; hence, one very rarely encounters a pure, “traditional” African culture (Ruth, 1999, Lesolang-Pitje, 2003, Madu, 2003). Peltzer (1999) argued that



with increasing urbanisation, traditional healers often seemed to fail to solve the patient's problem adequately when addressing newly structured psychopathologies like psychosomatic disorders, substance abuse and chronic diseases associated with a changed lifestyle. As a result, an increasing number of patients, particularly in urban areas felt the need for psychotherapy. Practicing psychotherapy within such diverse settings has its challenges. One such challenge involves dealing with clients with conflicts in their life resulting from cultural clashes, mostly because they are not practicing one pure culture (Nefale&Van Dyk, 2003, Van Dyk&Nefale, 2005).

***“To deal with mental health is to deal with culture and vice versa”***

Sam&Moreira (2002) claimed mental health and culture are intrinsically linked, to the extent that the definition of health depends on the prevalent culture in a society at any given time. Traditionally, in the west, mental illness has been approached with a bio-medical model. This approach is linked to an individualist ideology where mental illness is diagnosed and treated as something purely individual. Consequently the model is independent of culture.

Nefale&Van Dyk (2003) has claimed that countries of a multicultural nature, such as South Africa, tend to experience challenges whenever psychotherapy is involved, because most psychotherapy training has been based on such western and European models of illness, health, and healing. Applying the western based principles of illness and health to non-western clients could result in conflict (ibid). Peltzer (1999) described some of the problems encountered in psychotherapy with African clients. He said a lack of acceptance of psychotherapy has been explained as a lack of psychological mindedness, a lack of interest in introspection and reluctance to speak of family problems beyond the confines of the family. The tendency to somaticise has also been described with African clients, as well as the expectation of physical treatment in the form of medicine (ibid). Despite these difficulties, Peltzer (1999) claimed that both psychotherapy and psychoanalysis, a “purer” form of Freud's initial talking cure, are applicable in the African context. Madu (2003) argued that the aspects of western cultures inherent in these models should be replaced by corresponding aspects of African cultures. Ruth (1999) has supported this notion, exploring the rewards of using psychoanalysis to understand the South African psyche, focusing on the Truth and Reconciliation Commission as a rite of psychotherapy. One could argue, as Mitchell and Black (1995) stated, that we have Freud woven into the fabric of our culture. Psychotherapeutic thought has become constitutive of western culture and pervading the way people experience themselves and their minds. To substitute this with African aspects, then, one would need an African way of thought that is woven into the fabric of the African culture.

A philosophy that is constitutive of the way Africans experience themselves and their minds. I believe such a worldview exists in the concept of Ubuntu.

## **2.2 Ubuntu**

Despite the heterogeneity and dynamism of the African continent, there are commonalities that unite the African experience. (Bandawe, 2005). Bandawe argued that the “very fabric of traditional African life centred on community and belonging to a network of people”. This statement closely resembles the one made by Mitchell and Black (1995). In Africa, Bandawe claimed, human identity lies not in “I think therefore I am”, but in “I am because you are, and because you are, therefore I am” (Bandawe, 2005). The concept of Ubuntu is essentially an African philosophy of humanism. The word ubuntu is a Xhosa or Zulu word meaning ‘humanity’, ‘personhood’ or ‘humanness’, the Zulu idiom ‘umuntu ngumuntu ngabantu’, translated as ‘a person is a person through other people/persons’ defines the core of the philosophy. This saying illuminates the communal embeddedness and connectedness of a person to other persons (Bandawe, 2005). Similar idioms exist in Xhosa and Northern Sotho. (Van Dyk&Nefale, 2005; Fabian, 2001). Ubuntu has been seen as an orientation to life that is opposed to individualism. However, it is not in accordance with collectivism, where it stresses the importance of the social unit to the point of depersonalizing the individual. Both the individual and the social units are thus mutually reflective and important. (Fabian, 2001). In other parts of Southern Africa, this understanding is called Umunthu, Obuntu, or Utu (Lane, 2000, Swartz, 2006). Van Dyk&Nefale (2005) also propose that it exists in other languages like Kikuyu in Kenya: “umundu”, and Kizukuma in Tanzania: “bumuntu”. According to ubuntu philosophy, community is essential to subjectivity: a person is incomplete unless he or she maintains an active connection with the society or culture of which he or she is a part (Libin, 2003). Van Dyk& Nefale have argued that on an intrapsychic level, Ubuntu is not merely positive human qualities, but the very human essence itself. Ubuntu aims to provide a unifying vision of a community built upon compassionate, respectful, interdependent relationships; this includes one’s relationship with nature and with the spirit world. (Du Plessis, 2001, Outwater et al 2005) A human being strives to develop ubuntu through relationships. Individuals only exist in their relationships with others, and as these relationships change, so do the characters of the individuals. Striving for harmony, violence is not needlessly used, but in the just defence of the community, it can be used. Ubuntu serves as a rule of conduct, a social ethic, the moral and spiritual foundation for African societies (Louw, 1998 in Swartz, 2006) hence it was found to be a valid and representative perspective

to introduce when exploring psychotherapy's applicability to people of African cultural descent.

### ***2.2.1 Ubuntu in post-apartheid South Africa***

Ubuntu is rich currency in the dialogue around values and moral regeneration in South Africa. It is used in various government reports, such as the South African constitution, the education transformation policy document, and the white paper for social welfare. It is also liberally employed in various sections of the TRC report, especially regarding reparations and amnesty (Weingarten, 2000; Libin, 2003; Jones, 2006; Swartz, 2006).

In addition, Ubuntu in South Africa has become closely linked to one person: the Archbishop Emeritus Desmond Mpilo Tutu. The South African journalist and writer Antjie Krog who followed the Truth and Reconciliation Commission (TRC) hearings chaired by Tutu, argued that Ubuntu is the base for his theology (Gylseth, 2006). Tutu's Christianisation of ubuntu has enlarged upon the traditional conception of ubuntu, which originally included only kinsmen and close family members, and those who are 'black' not 'white' (Libin, 2003). Ubuntu as theology provides further incentive to embrace communalism and reconciliation and to become part of 'the rainbow people of God', a phrase for which Archbishop Tutu has become renowned. Through him Ubuntu has become the foundation of South African forgiveness (Jones, 2006). Tutu argued that those complicit in the apartheid regime's systematic project of torture, displacement and murder were also 'victims' of apartheid, because they became disconnected from the spirit of ubuntu essential to the welfare of the individual and the maintenance of the healthy body politic. The idea that one loses something through forgiveness has been rejected by the Ubuntu principle. One in fact gains or retains one's humanity. This has been explored in a psychotherapeutic context by Pumla Gobodo-Madikizela, a South African Psychologist who served on the TRC. For her doctorate, she conducted a series of interviews with Eugene De Kock, leader of the South African government's death squad, and also known as "prime evil". He was convicted after the TRC hearings and is incarcerated for crimes against humanity during the Apartheid years. Gobodo-Madikizela began her interviews condemning his horrible acts but came to understand that, while more comfortable to understand him as some form of "other" in order to understand his perpetrations, De Kock was a human being and his humanity became evident through these interviews. But in order to fully regain his humanity, he must be reinstated into society. A "person is a person through other persons", one can only be human when recognised as such. (Gobodo-Madikizela, 2003)

### ***Abuse:***

Ubuntu has been abused by government in a range of equally prominent ways, becoming entrenched in the problematic discourse surrounding the rebuilding and transition in South Africa. The government has utilised its concepts of sacrifice and reconciliation to promote the same amongst historically disadvantaged South Africans, encouraging them to be patient “in the spirit of ubuntu” while actually asking them to give up or delay legally acknowledged claims of monetary compensation or land (Swartz, 2006, Libin, 2003). Ubuntu also emphasises traditional values, such as respect for and loyalty to rulers. The government has abused these ideas to aid the introduction of ongoing policies of modernisation, delaying the redistribution of economic resources. Ubuntu, like so much else in the aftermath of apartheid, has been abused to conceal the need for redistributive justice (Swartz, 2006, Libin, 2003).

### ***Criticism:***

There are also major criticisms of the ways in which Ubuntu has been employed by blacks; as support for a demonisation of western liberalism and individualism, Africanist tendencies and a glorification of a pre-colonial fictionalised past that attempts to create a reconstructed traditionalism (Libin, 2003). A more serious allegation was of a tendency to silence critics in the name of loyalty (Marx, 2002 in Libin, 2003). Enslin&Horsthemke (2004) challenge its purported uniqueness. They argue that it is conceptually and practically associated with a long and profound tradition of humanist concern, caring and compassion, also prominent in western thought. This perspective, while originally a criticism, actually underscores the notion of an existing psychic unity and lends support to my selection of the philosophy as a counterpart to the psychoanalytical school of thought. It also suggests a sameness of causes of psychological distress, which would make cross cultural psychotherapeutic work with clients of African descent much less complicated. Libin (2003) argued that from the angle of Archbishop Tutu’s ubuntu theology, a community is fundamentally pluralistic, and so the person relating to that community must always be in process. Since individuals exist only through their relationships with others, their identities change as their relationships transform. These are perspectives easily related to the psychotherapeutic room.

## **2.3 The third room in therapy**

Thirdness is a concept that has been introduced to psychoanalysis alongside the idea of intersubjectivity and relation (Binder et al, 2006). Much has been said, thought and written about thirdness and scholars apply the term with a variety of meanings. (See Hanley, 2004 for

a historical analysis of the third; Green, 2004 for a discussion of thirdness and psychoanalytic concepts and Minolli&Tricoli for an outline of the third and self-consciousness) I have chosen to depict the concept of the third and thirdness in accordance with how they have been constructed and applied by the analyst Jessica Benjamin. This choice of theoretical approach to thirdness stems from Benjamin's view of thirdness as co-created and shared by therapist and client, a space in therapy where recognition and mutual understanding is possible. This is also something my informants underlined in their practices. In her article "Beyond doer and done to: an intersubjective view of thirdness" from 2004, Benjamin also addressed how therapist and client arrive at co-creating thirdness. In essence, this is also what my exploration is about, though placing this quest in the specific context of crosscultural therapy. I have investigated how to create thirdness in a context where differences were increased both in terms of magnitude and multitude. Therefore, Benjamin's approach to how this could be done within the frameworks of conventional intersubjective theory was of value to my study.

### ***2.3.1 Intersubjectivity***

In order to fully understand the concept of thirdness according to Benjamin (2004), one needed to briefly visit the notion of intersubjectivity. Benjamin defined intersubjectivity as a relationship of mutual recognition, where each person experiences the other as a "like subject", another mind who can be "felt with", yet has a distinct, separate centre of feeling and perception" (p.5). She compared intersubjective interaction to that of "the confusing traffic of a two-way street"(p.6). How individuals experience intersubjectivity however, to her mind, was very different; it was that of a one way street, where one person is the subject, the "doer" and the other one is the object, the "done to". This experience, some of my informants argued, was exacerbated when western scientists do cross-cultural research. Benjamin's point, however, was that we all tended to feel this dynamic in complementary relationships, that generally, one tended to feel like the "done to", and not like an agent helping to shape a co-created reality.

### ***2.3.2 Complementary relationships: twoness***

One way of seeing psychotherapeutic work, is through the alternation of breakdown and renewal in the psychoanalytic process. (Benjamin, 2004). She has formulated the contrast between the twoness of complementarity and the potential space of the third. She argued that complementary twoness was the formal or structural pattern of all impasses between two people, and this was where intersubjective theory found its real challenge. Ogden (1994) has said that at the core of complementary relations, or twoness, is the conception of only two

choices: submission, or resistance to the other's demand. Benjamin claimed that characteristically in complimentary relations, each partner felt that their perspective of how this is happening is the only right version, or, if acknowledging another perspective, the two are irreconcilable, expressed in the statement "either I am crazy or you are". Benjamin argued that as a clinician, one would get caught in such interaction and often, on a deeper level, attribute blame to the self, something she believed weakened one's sense of being a responsible agent. An important relational idea for resolving such impasses, is the belief that the recovery of subjectivity required the recognition of our own participation. Once a clinician accepted her own contribution and its inevitability, the fact of two-way participation became something one could understand and utilise. Surrendering to the principle of reciprocal interaction makes responsible action and freely given recognition possible. It also opens the space of thirdness, enabling the dyad to negotiate differences and to connect. Benjamin believes that surviving the breakdown into complementarity and twoness and the subsequent restoration of dialogue is an experience crucial to therapeutic action, and that a more advanced form of thirdness emerges.

### ***2.3.3 The third***

Benjamin argued that to the degree that we ever manage to grasp two-way directionality, we do so only from the place of "the third", a vantage point outside the two. The concept of the third has multiple meanings in psychoanalytic theory, and different scholars give the concept different content. Gerson (2004) argues that for some, this "something called a third that transcends individualities" (p.64), is thought of as a product of an interaction between individuals, others describe it as a context that originates apart from us even as it binds us together. I will refer it briefly according to Benjamin's understanding, to the extent it is needed to illuminate her concept of thirdness. She assumes the relational view of the third, which, rather than seeing it as a thing to be acquired, sees it as an interactive process that creates a dialogic structure that Benjamin calls a "shared third". The shared third is an opportunity to experience mutual recognition and creates a mental space for thinking as an internal conversation with the other. Benjamin states that "the only usable third, by definition, is one that is shared" (2004, p13). She described a world without shared thirds as a place where everything is "mine or yours" (2004, p.22), including the perception of reality. To construct the idea of the shared, intersubjective third, Benjamin has brought together two experiences of thirdness, the "third in the one" and the "one in the third". She exemplifies the third in the one, which she also calls "the moral third" with the mental space of thirdness in

the caretaker; a mother's ability to maintain awareness that the child's distress will pass alongside her empathy. Benjamin proposes that analogously, a therapist can help soothe or regulate a client by maintaining this position of thirdness. For the therapist, an absence of this type of thirdness might result in a feeling that her separate aims, being a person with independent needs, would hurt the patient. Benjamin calls such a relation a perversion of the moral third, which is accompanied by a "kill-or be killed" complementarity and an absence of recognition of the other's separateness.

In Benjamin's view of thirdness, recognition begins prior to verbal communication. Benjamin argues that the earliest exchange of gestures between mother and child is a form of thirdness. As this relationship has been called oneness, Benjamin calls the principle of affective resonance or union that underlies it "the one in the third" and describes it as the part of the third that is constituted by oneness. While the experience of complementary twoness is characterised by action-reaction, a shared third is experienced as a cooperative behaviour. Benjamin compares the thirdness of attuned play to that of musical improvisation where one receives and transmits simultaneously in nonverbal interaction. The co-created third, then, has a transitional quality of being both invented and discovered at the same time.

#### ***2.3.4 Thirdness***

One of the aims of the article "Beyond doer and done to", Benjamin stated, was to address how human beings develop the shared third. She regards thirdness not as a "thing", in the way theory or rules of technique are things, something to be used or applied. Rather, she sees it as a quality, a space, an experience of intersubjective relatedness, a relation. (Benjamin, 2004). She says it has its correlate in a certain kind of internal mental space within the individual (Ibid). The aim was to grasp the creation of thirdness as an intersubjective process. Benjamin argues that in shifting to an intersubjective concept of the third, one grounds an alternate view of the clinical process to when the concept is being used to refer to observing capacities and the analyst's relation to his own theory or thinking. When thirdness is seen as something the therapist relates to internally in therapy, the patient might be excluded from what becomes the essential therapeutic dyad instead of building a relation together with the therapist. The result might be that the patient attacks this thirdness. One way recognition, such as this becomes, misses the mutuality of identification by which another's intention becomes known to us. Benjamin argues that to separate being understood from self-reflective understanding or understanding the other misses the process of creating a shared third as a vehicle for mutual understanding. She distinguishes the third from ideals which therapists might hold on to with

their ego and argues that in the space of thirdness, one is not holding on to a third, one is surrendering to it. Elaborating on this notion of surrender, Benjamin argues that one could see the concept of the third as what one surrenders to, and thirdness as the intersubjective space that results from surrender. With regards to the concept of surrender, she drew on Ghent's work (1990, in Benjamin, 2004) making a distinction between surrender and submission. The fundamental dissimilarity being that while submitting to someone, surrender was rather letting go into being with someone. Benjamin regarded surrender as a letting go of the self which also implied the ability to take in the other's reality and would refer one to recognition and the ability to sustain connectedness to the other's mind, while accepting his separateness and difference. Surrender also implied freedom from any intent to control or coerce, and the creation of thirdness is allowed through recognition of mutual influence.

### ***Creating thirdness:***

One of the most common difficulties in therapy, according to Benjamin, is where the patient feels "done to" by the therapist's observation or interpretation. She argues that such interventions trigger self-blame and shame in the therapist, and that these difficulties erroneously have been called "resistance", while actually reflecting intersubjective resistance to the analyst's projection of the shame and guilt of hurting the patient. The most important principle to overcome this shame and blame in therapeutic work, lies in the idea that recognition continually breaks down, that thirdness collapses into twoness and that one is always losing and recovering the intersubjective view. Breakdown and repair are part and parcel of the therapeutic process. She argues, in line with Mitchell (1997, in Benjamin, 2004) that becoming part of the problem is how the therapist becomes part of the solution. When speaking of surrender to a third, Benjamin underlines that surrender is not something only required from the client. The therapist's surrender implies a deep acceptance of the necessity of becoming involved in enactment and impasses. Until the relational third view came, she argued that many analysts thought interpretation was the primary means to institute the third. Relational analysts, however, have explored ways to collaborate with the patient in exploring or exchanging perceptions in order to open up the space of thirdness, rather than just providing an interpretation. Benjamin claims the latter can appear to be a defensive insistence on one's own thinking as the necessary version of reality. How does one restore thirdness once it has collapsed into twoness? Benjamin believed this is done by the therapist having to change her mode of interaction. In many cases this is what first leads the client to believe that change is possible. The way to achieve this, is by acknowledging one's own struggles as a therapist and accept loss, failure, mistakes and one's own vulnerability. There are cases where



the patient's confrontation and the therapist's subsequent acknowledgement of a mistake, misattunement or an emotion of her own is the crucial turning point. A dyadic system that provides a safe space for such acknowledgement enables both therapist and client to step out of the symmetrical exchange of blame. If it is no longer a question of whose reality takes precedence and the therapist is able to acknowledge the patient's suffering without stepping into a position of badness, the intersubjective space is restored. By making a claim on the potential space of thirdness, Benjamin argues, one can call it into being.

This ameliorative action is also seen as the moral third, reachable only through the experience of taking responsibility for bearing pain and shame. In taking such responsibility, the therapist is putting an end to the interaction where client and therapist alternate in trying to place blame or the bad into the other. What the analyst, in effect, is doing, is to say "I'll go first", hence demonstrating the route out of helplessness through the moral third of responsibility. Seen in another way, the re-establishing of thirdness after collapse is a reconciliation. In a footnote regarding this topic, Benjamin discussed a personal correspondence with Drucilla Cornell from 2003, where Cornell outlined the principle of Ubuntu and its connection to the South African reconciliation process, hence drawing a comparison between the reconciliation post-apartheid and the reconciliation in therapy. Cornell explicated the principle of Ubuntu as meaning "I'll go first". In calling this act on part of the therapist the moral third, Benjamin suggests that clinical practice may ultimately be founded in certain values, such as the acceptance of uncertainty, humility and compassion that form the basis of an egalitarian view of psychoanalytic practice.

### **3. METHOD**

#### **3.1 Choice of method**

Henwood and Pidgeon (1992, in Hill et al 1997) have stated that qualitative research emphasises description rather than explanation, represents reality through the eyes of participants and stresses the importance of viewing the meaning of experience and behaviour in context and in its full complexity. The nature of the phenomenon that I have chosen to explore required a qualitative research methodology. Hill et al. (1997) have argued that qualitative methods offer a unique way to address the phenomena that are more complicated, infrequent or otherwise will not be captured in a quantitative research process. Several researchers have agreed that in qualitative research one views the scientific process as stressing the emergence of concepts from data rather than an imposition of data into existing theory. (Ibid)

My focus has been on whether it is possible to create thirdness – a “third room”<sup>5</sup> that can generate healing between a therapist and a client across cultural borders. In-depth information about interaction behind the closed doors of therapy-rooms has been the goal of the investigation. These rooms are protected by confidentiality clauses in any setting, and one of my presumptions was that they were also shut more tightly by the fear of some therapists that their work would deviate from a norm or “western golden standard”. Choosing a qualitative method enabled the expression of results linguistically rather than numerically and interpreting and reporting events in their context, imperative in this study.

Although interviewing professionals, the investigation still covered delicate ground, exploring what was challenging about their work and what their struggles were. I was asking them to show me what they felt they did not master, their insecurities. These were personal questions and would touch the therapists’ professional identities, a vulnerable space for any professional, but particularly to psychotherapists. The nature of psychotherapy is to be both observer and participant, a task linking the personal and professional identities closer together. One is expected to be personal in psychotherapy, but one cannot afford to be private, but in this exploration asked therapists to explore how these arenas were interconnected. Hence the choice of the semi-structured interview as the most appropriate research tool. Epistemologically, I shared the view of many qualitative researchers that researcher and participant have mutual influence on each other. The participant is seen to teach the researcher about the phenomenon, and the researcher influences the participant through the probes used to help the participant explore his or her experiences. (Hill et al 2005). In this study, this was even more prominent, as I was interviewing experts of my own profession.

### **3.2 Procedure**

Selecting informants was a procedure that lasted for about two years, initiated while I was studying at the University of the Western Cape in 2004. During my internship in South Africa in 2006, I discussed selection criteria with both my Norwegian and South African supervisors, pulling on their knowledge of what the different South African therapists’ experiences were, to decide on a suitable informant group. Ms. Duckert has set up and worked with an exchange programme of Masters and Doctorate students between South Africa and Norway since 1994, closely watching and developing it. She is also a member of PSYSSA, Section for clinical psychology in South Africa. Ms. Walaza was trained in South Africa and graduated as one of the first black psychologists from a previously white university. She knew and had worked

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<sup>5</sup> A term taken from Relational Psychoanalysis, see the section on Theoretical background for an introduction.

with many of the most experienced clinicians in the country. Together, their contact bases and knowledge were a unique source of information. The sample selection was finalised in medio 2006, and a group of 12 therapists were approached. They were contacted via telephone and asked if they would be willing to grant an interview. If such an interest was present, they were sent a description of the study's aim and the interview guide via email. 3 therapists declined participation on grounds of shortage of time or because it was impossible to conduct the interview face-to-face. 9 therapists agreed to grant interviews. All save one interview were done in South Africa within the period of two weeks in July-August 2006. The last interview was done in Norway in October 2006.

### **3.3 Sample**

My total sample comprised of 9 informants. Therapists were selected based on my two supervisors' and my own knowledge of therapists who fulfilled the following selection criteria: competence within the cultural arena, experience in teaching future therapists and ethnic background:

#### ***Competence within the cultural arena:***

Having spent a sufficient amount of time working in the cross-cultural context was an important experience for the selected informants to have. The hypothesis was that only through feeling this context up close would therapists have the in-depth knowledge of the nuances of providing therapy in a cross-cultural setting.

#### ***Experience in teaching future therapists:***

As one of the initial research questions was to investigate how to make future therapists better equipped to deal with working in a multicultural setting, it was important that the South African therapists had an insight into what was status quo in this area. It would also be significant for them to have grappled with how to best construct a clinical programme that would incorporate a cross-cultural perspective.

#### ***Ethnic background:***

This criterion focused on selecting a group that was representative of South African society. Hence, at this point, homogeneity was not the ideal, as the South African population is diverse. The therapist population in the country did not yet reflect the general population, making it even more important to have as heterogenic a group as possible, exploring the struggles of therapists belonging to the previously disadvantaged racial groups. It was also important to capture the African therapists' reflections on psychotherapy opening for a possibility of diversity in opinions across racial or cultural background. The sample reflected

the desired diversity of the future South Africa. It consisted of two black female therapists, one black male therapist, one so called “coloured” female therapist, one “Asian” male therapist, one white female therapist and three white male therapists.

### **3.4 The interview**

#### **3.4.1 Interview guide**

Developing and formulating the interview guide was possibly the most challenging part of the exploration. Wording the questions right was of utmost importance and I spent three full months developing the interview guide, from May to the end of July 2006. Within the tradition of qualitative research, there has been a debate around the most viable way to develop an interview protocol: Hill et al. (1997) encourage researchers to review the literature to determine what has been done before so that they can build on previous research. In contrast, other qualitative researchers favoured limiting exposure to the literature because of the potential for influencing one’s thinking. (Hill et al 2005). Though I knew material existed on similar topics to my own, I decided to develop my questions by talking to people from the target population and examining my own experiences with the phenomenon. This was possible as both my supervisors were also part of my target population, and had they not been my supervisors, they would have been valuable informants.

Finally, a semi-structured interviewguide of 16 questions<sup>6</sup> was presented to the sample. The questions were broad, exploring their views on western psychotherapy, its applicability in South Africa, traditional healing, their own backgrounds, the content and form of their work, and the possibility of transcending culture in the therapeutic space. Training of future therapists was also addressed, both inquiring about the present situation with regards to education in cross-cultural therapy and about possible improvements for the future. The interview guide also contained a set of background questions addressing the therapists’ professional training and work experience. All interviews were conducted in English, although not all of the therapists have English as their first language.

#### **3.4.2 Conducting the interview**

There are multiple ways to conduct an interview and as the trustworthiness of the study depends on the quality of the data collected, this was an important factor. The therapists selected were extremely busy, and in being approached, many of them asked if they could answer the questions via telephone or e-mail. This request was declined. There were multiple motives for this: the topic of investigation was seen to be complex and it was my opinion that

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<sup>6</sup> For the complete interviewguide see appendix

a physical presence would allow the participants and the researcher a higher degree of security and hence create a space of mutual candour that would not be as easily created over the telephone or in writing. Accordingly, all participants were interviewed face-to-face and all the interviews were recorded by a digital recorder. The informants were aware of and had agreed to the use of such a device. They were also asked if they had any hesitations or apprehensions against being quoted directly. None of the participants expressed any such hesitations.

Three of the participants were interviewed in offices at The University of Cape Town campus, one was interviewed in an office at The University of The Western Cape campus, one in an office at Stellenbosch University, two in offices at HCSR in Cape Town city centre and one in a private home in Oslo, Norway. No monetary benefits were given for participation. The interviews lasted between half an hour and one and a half hours, the average being a little over one hour. All were carried out by myself and mostly without disturbances, though there were incidences where short intermissions of up to five minutes had to be made. At the end of the interview, participants were asked if they had anything to add or if there were questions they felt had not been asked or topics that had not been addressed. This was done to open for approaches to the research topics that I might not have been aware of and hence not thought to ask about. However, none of the therapists had anything to add.

### ***3.4.3 Transcriptions***

To transform data from a face-to-face conversation to written text without losing or distorting any information is a somewhat impossible task. When utilising oneself as a research tool, the way the researcher experiences the interview will influence the presentation of the material. Secondly, no matter how extensively, precisely and meticulously one converts the dialogue into writing, one cannot encompass everything that is being conveyed in such a meeting. Some researchers (See Nørbech&Farshbaf, 2007) have chosen to transcribe their interviews also including non-verbal material such as gestures and facial expressions. In this study, however, this was not included. Psychotherapists are a group well acquainted with the fact that how you word something, your intonation and prosody will impact on what meaning will be interpreted into the response. Hill et al. (1997) have stated that sighs, laughs, stutters, nonlanguage utterances (“er”, “um”) and fillers (“you know”, “okay”) do not need to be transcribed into verbatim (p.543). When choosing to include them in my transcriptions, I did so due to the fact that in this exploration these elements were seen as verbal mannerisms that

gave a more in-depth picture of each therapist. Although depending on the participants' eloquence and precision, this material was also considered valuable information. Though not included in the final text, the therapists' verbal mannerisms are often included in the quotes given.

### **3.5 Methodological considerations**

This section will direct attention to issues that might have affected the data collected or the analysis of these data and thus the outcome of this exploration. Methodological considerations may be divided into expectations and biases (Hill et al 1997). Expectations can be defined as "beliefs that researchers have formed based on reading the literature and thinking about and developing research questions" (Hill et al 1997, p. 538) and biases as "personal issues that make it difficult for researchers to respond objectively to the data" p. 539).

The research questions will have been subject to the researcher's presumptions and theoretical preconceptions. I entered the investigation as a clinical psychology student with a clear theoretical grounding. This has had an influence on the selection and wording of the questions for the interviewguide, the conducting of the interviews and my analysis. I also had my hypotheses of what it was like to practice psychotherapy in the South African context and of the challenges one might meet in cross-cultural therapy. But as Nørbech&Farshbaf (2007) have asked: Is it at all possible to approach a phenomenon without leaning on previous knowledge?

When selecting participants for qualitative research, there is always the risk of a group being formed by availability and willingness for people to participate. In the case of psychotherapist participation as in this study, looking to literature, Hill et al. (1997) address difficulties in recruiting therapists to participate in psychotherapy studies. They even discuss the option of monetary compensation. I did not experience an unwillingness to participate in my study, quite the contrary. Some of the therapists took time off from extremely crowded schedules, sickleave and other obstacles to grant the interviews. As abovementioned, no monetary compensation was offered for participation in this study and a samplebias based on participants accepting the offer for purposes of economy or other compensation was therefore not an issue. Nor did I make any exceptions or special provisions with regards to availability. The three therapists who declined only left me three participants short. I did not review my sample pool to try to replace them with other informants.

Another factor is the ever present risk of informants giving what they feel is the "right" answer, trying to please the researcher rather than expressing their actual opinions. In South

Africa, given the country's history of oppression and forced compliance, this was a salient issue. When analysing the material, one of the interviews bore a particular resemblance to such a pattern of contestation. This is addressed in the analysis, and being a qualitative study, such a pattern could also give valuable insight in analysing what informant chose not to say or respond to.

Additionally one could ask if the interviews were open enough to leave room for surprises and twists. The informants free-associated around the questions, sometimes answering them in advance or diverging into a topic they found more relevant. This was allowed and encouraged.

Generalizability was another consideration. The therapists in my sample were all working in the Cape Town area at the time, save one, but the selection based on experience provided a heterogenic sample with a wide range of training backgrounds and workexperience. Moreover, as argued previously, the focus was on therapists working in a multicultural setting in South Africa. Cape Town can be said to be one of the most "mixed" areas culturally. The question, however, remains whether these findings can be valid for other therapists working in differently assembled multiethnic environments?

A final issue that could be considered an asset rather than a bias, but might nevertheless influence how the material is presented, is the fact that the author is of mixed cultural background.

### **3.6 Ethical considerations**

The nature of qualitative research can make it difficult to foresee what ethical concerns might arise before the study is actually in progress. Moreover, these concerns are often more salient when investigating vulnerable groups, focusing on possible negative effects of the investigations. In such cases meticulous preparations are made and ethical boards at the relevant research institutions closely scrutinise every aspect of a project proposal before giving their consent.

These issues were discussed in relation to this study, and it was decided that no informed consent form was needed due to the type of informants being approached. Both supervisors were in accordance with regards to this issue. The rationale for reaching the decision was that this was a population well aware of research procedure and educated in the field of academia. It was thought that being informed of the nature of the study, that it was made in connection with the writing of a thesis in clinical psychology and further being given the questions in advance, would make the therapists more than qualified to give an informed consent. It was

also assumed that agreeing to the interview could be taken as such an informed consent. Additionally, it was argued that the questions in the interview guide were not of a delicate nature. They addressed the professional aspects of the informant and though some of the questions also explored how the therapists' personal background influenced their work, it was thought that this was a resourceful group more than able to control how much information and what type of information they chose to disclose.

The second ethical consideration was whether one should anonymise the therapists. This might seem an odd consideration to make after deciding these are professionals being interviewed about their work and their expertise. There was an important nuance, however: if the therapists were to be identified in the text, one would be given access to their personal, or more correctly: their *private* struggles and experiences. As mentioned, it is difficult to foresee at the start of a qualitative research project which ethical issues might arise, and so it was only when actually interviewing the therapists it became clear the degree of self-disclosure, candour and sincerity displayed in their responses. Some of the interviews bore considerable likeness to a therapy-session, the interviewer being a guide to an introspection of the development of a therapeutic identity and how this identity influenced the way therapists worked, what clients they preferred and what challenges they met and why these issues were considered difficult. Having been awarded such material, it was considered to be a responsibility to protect the informants. It was decided that pseudonyms would be applied, and an anonymised background would be presented for each informant built on the background questions<sup>7</sup> each informant answered and some additional information given in the interviews. These questions provide information about ethnic and cultural background, training and what populations they had worked with. The therapists were each given initials following the sequence of the consonants in the alphabet; bb, cc, dd etcetera. Utilising such pseudonyms was thought give a certain degree of protection from identification, and would also protect the informants' clients when difficult cases were described.

### **3.7 Data analysis**

After completing the interviews, I listened through them a few times before transcribing them. On exiting the different sessions, I always brought with me a sense of atmosphere or sentiment regarding the interview. I listened through them and found that my initial sense of atmosphere was consolidated. However, once I started transcribing the interviews, I found that entering into the material more in-depth, my perceptions changed with regards to some of

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<sup>7</sup> See appendix



the interviews. To exemplify; the shortest interview was 25 minutes long, and I was left with a feeling that the responses were superfluous and insufficient. When transcribing this interview, I found that they were insightful, accurate and very much to the point. While the other therapists had free-associated and sometimes completely deviated from the question, even forgot it, this therapist simply answered my questions precisely and thoughtfully.

After transcribing the interviews, I edited the material according to the initial questions from the interviewguide and did a preliminary analysis to get an overview of the material. Through the preliminary analysis process, a set of topics for analysis emerged. I structured the topics of analysis according to my research questions, producing the four following themes:

1. Challenges for a westernly schooled psychotherapist in South Africa
2. Cultural African elements that influence psychotherapeutic work
3. Adjustments for a better suited psychotherapy in South Africa
4. A therapeutic meeting that transcends culture? The prospect of Thirdness.

## **4. ANALYSIS**

### **4.1 The Therapists**

**BB** was an African black therapist from Malawi who was trained in South Africa. His research interests were social Psychology and in particular cultural aspects of human behaviour and health, anthropological psychology and Ubuntu psychology. He was teaching at one of the most prominent universities in South Africa. He described his background as very global and has worked with the full range of clinical populations in terms of age, race and gender. He has practiced as a therapist for a little over 10 years, has a doctorate from Africa and has published articles in African medical journals.

**CC** was a therapist that would be classified as “Asian” during apartheid rule, but he defined himself as black. He was primarily English speaking, but taught at an Afrikaans speaking university; a formerly all-white university of stature in South Africa. He was trained in what he defined as “the West”, and had a Masters degree and a Doctorate both from different universities in the United States. His research interests were focused on Post Traumatic Stress Disorder and former political detainees. He had worked with a broad range of patients: in South Africa with trauma patients and in the USA with patients with chronic mental illness, at a university counselling centre, in a community clinic and with inner city African American children and adolescents. He was a practicing Muslim, the first one on his staff. He taught and supervised Masters students.

**DD** was a white female therapist with family origins from one of the European islands. She described her culture of origin as a patriarchal one and says that it has influenced her personal history though she is born and raised in South Africa. Her research interests were gender based violence, trauma counselling, training in primary health care setting, effects of race, class and gender on mental health and community psychology. She was trained in South Africa and described that training orientation broadly speaking as psychodynamic, though generic, covering psychopathology, community psychology, grouptherapy, individual work and child and family work. In the little over 10 years she had been a therapist, she had not worked in private practice, but for a Non Governmental Organisation providing help and therapy to survivors of violence and torture, and with the government providing psychotherapeutic training for nurses and frontline service providers. She convened a Masters clinical programme, and taught and supervised at the university connected clinic.

**FF** was a white male therapist considered to be one of South Africa's prominents on culture and mental health. Born in South Africa, he was trained during apartheid at an all-white university and qualified more than 25 years ago. He described his training as generic, with a major psychodynamic emphasis. He was trained in family therapy, grouptherapy and behaviourtherapy. His client population through the years has come from a range of backgrounds, he has worked with individual clients in private practice; mainly wealthier white people and with various organisations the broader range in terms of race, fewer Xhosa speaking clients than other races, though he said his Xhosa is not terrible. He had seen the full range of ages and worked extensively with organisations and community groups. He has travelled a lot in Europe, USA, Australia and Africa, and held workshops in, among other places, Norway and Holland, though he has not seen clients abroad. He has been head of psychology departments of two of the well established universities in South Africa and was running a department at one of the Afrikaans speaking universities. A native English speaker, he defined himself as a "de-tribalised Jew", held a doctorate and has published extensively.

**GG** was an African black female therapist. Originally working as a nurse, she grew up in the apartheid era, and was trained at one of the previously coloured and black universities in the early transition period around 1994. She described her training as generic, covering a lot of the schools, amongst them the psychodynamic and cognitive behavioural therapies. Her own preference has been psychodynamic work and object relations therapy. Her research interests

were psychopathology and race, psychodynamic theories of personality development, HIV/AIDS, public health care provisioning, mental handicap and psycho-legal issues. She has worked mostly with young, black women in her private practice. She described them as upper middle class and well educated with jobs that allow them to afford individual therapy. She has done some assessments with children, especially when the child does not speak English, but prefers working with adults. Her therapies were from one year up to five years of duration. She also did assessments of mentally handicapped children who have been sexually abused preparing the court for their evidence. She has taught and supervised in both previously black and previously white universities, had a doctorate and ran a clinic at one of the previously white South African universities, training clinicians there.

**HH** was a white male therapist, trained during the apartheid era. He has trained at different very well reputed universities in South Africa, travelling extensively within the country. He has a doctorate from a South African university and post-doctoral training in clinical work from the US. He qualified as a clinician over 25 years ago and said the predominant training was psychodynamic therapy, both short term and long term models. Though the training was mainly psychodynamically informed, it had a theoretical base covering also from self-psychology. HH has extensive experience from working in the hospital system in different major cities of South Africa. He has worked in satellite clinics and run clinics in most of South Africa's largest townships, both during and after apartheid. Additionally, he has done counselling work with detainees, invariably black South Africans. He has seen children, teenagers and adults from all racial groups. In his work in the United States, about sixty percent of the clients were African Americans. He was heading a psychology department in one of the previously black and coloured universities in South Africa.

**JJ** was a female coloured/black therapist who trained and qualified after the abolition of apartheid in 1994, but who was born and raised in the country during apartheid rule. She trained in South Africa at one of the previously white universities. Her research interests were gender and crime, women and girl offenders, gender-based violence, mental illness and crime and capacity defences, critical psychodiagnostics and the social construction of mental illness. She described the core of her training as mainly focusing on the psychodynamic paradigm. Her client population has been from previously coloured areas, Afrikaans speaking and what she described as a very disadvantaged population. Subsequent to getting children, she stopped her private practice and now mainly sees clients on a pro bono basis. She taught at one of the

most popular, previously white universities in South Africa and has published articles and contributed to books, mainly on child psychology and therapy.

**KK** was a white male therapist who finished his training in the seventies. He was also the one with the most intriguing training history. When asked what kind of therapist training he had, he answered “pretty useless to be honest”. He explained that at the time, if one did not have the resources to train at a university doing coursework, one could do two years of training time in a mental hospital, and give in a dissertation. He worked at what he described as a “dreadful mental hospital” for two years, describing it as an unpleasant place to train and his time there as a difficult one, having to make very hard moral choices. Being trained under apartheid rule, he experienced nearly being thrown out of the hospital because of asking why black patients didn’t get anaesthetics when they had electroshock therapy and other apartheid rule imposed differences. He was given the choice of either accepting these rules or never to train in psychiatry. He stayed on and tried to do what he could, but regards his therapy training to have come at a later stage. He did training in family therapy at one of the most prestigious Ivy-League universities in America and trained in brief psychodynamic therapy at two reputed institutes in London shortly after he qualified. His client population has been of many kinds: during apartheid rule, he worked with people who were in the underground or who had experienced torture, also giving testimony in political trials as a clinical psychologist for the defence, where there were questions around admissibility of confessions that were made and solitary confinement or other conditions of torture. He worked with groups of children, adolescents, youth or their families who had been in prison or were in prison and was prominent in setting up a mental health worker’s group, an NGO that had branches in all the largest cities in South Africa. It had detainee clinics that were run after hours. He also did training and lay counselling. All these services were free, the therapists involved worked as volunteers part time and in the evenings and weekends. KK worked as a lecturer at the same time. He worked at a university clinic with families and children with emotional and scholastic difficulties and he considered himself to be mainly a family and child person. Around 1994 he stopped doing clinical work. He explains that he felt he needed to rest and do something else. He was working as a researcher and did preventive work at the time of the interview, especially with young people. He has travelled and worked in both Europe and Africa, has a doctorate and has published extensively.

**LL** was an African black female therapist who trained over an extended period at two of the previously black universities in South Africa. She has also done part of her training in the United States and did her doctorate in collaboration with a University in Norway. She trained during apartheid rule and was qualified in the transition period. She had been trained in an eclectic fashion, but inclined towards the cognitive behavioural approach. Her client population covered all the different populations in South Africa in terms of race, though percentagewise more black patients. She has worked with all age groups. She was heading a psychology department at one of the previously black universities in South Africa and has taught courses in cross-cultural counselling at a university in Norway.

## **4. 2 Challenges for a westernly schooled psychotherapist in South Africa.**

### **4.2.1 Psychotherapy's culturality**

*"People, wherever you are value being listened to, being able to tell their story...and on their own terms, you know? I think that's a commonality that goes across cultures..." (KK)*

One of my assumptions about working with psychotherapy in Africa, was that it would be difficult to apply psychotherapy in its purer form. One might say that there are three different cultural backgrounds in any therapy room: the client's, the therapist's and the cultural background of the chosen mode of healing, in this case psychotherapy. My inquiry was on whether that mode of healing is determined by its background when applied. Did my informants feel directed by where it is coming from? If so, how did they address this in order to successfully apply psychotherapy? My hypothesis was that therapists would share the somewhat pervasive idea in cross-cultural psychology, that originating in the West, psychotherapy as a theory, or "invention", carries its own mindframe that is reflected when applied it.

***"It all goes back to Freud, but that's different from saying it's culture bound":***

When I asked the informants whether they saw psychotherapy as a culturally determined tool for healing, they all had some reservations to their affirmative answers, but were in accordance on the fact that as psychotherapy originated in the west, with Freud, it hence carried a certain ideology, and western theory was guiding it. DD, coming from a feminist perspective, said that it had come out of a very particular western model, and was embedded in capitalism and an individualist position. She said she had difficulties with its history being dominated by white men. However, informants cautioned against looking at this deterministically, implying that psychotherapy cannot evolve and adapt to other cultural settings. As FF put it:

*"It's based very much on 19<sup>th</sup> century concerns in the West, but that's different from saying it is culture bound."*

He found the assumption problematic and more complicated than it would appear, as what one defined as “western” could be unclear. The topic FF touched briefly upon, concerned the dynamics of culture, and the fact that increasingly African countries are integrating western ideals and values, making the lines blurry. No society in modern times can be said to be completely monocultural, or uncultural (Berry et al, 2002).

KK did not see the “talking cure” as culture blind, quite the opposite. He thought the idea of “talking oneself to a cure” to be not only western and modern, but specifically a mid 20<sup>th</sup> Century idea. He cautioned that although effective within a particular cultural genre, this did not imply it would be good for everyone. He also defined it as a bourgeois phenomenon, and said that some of the ways of thinking attributed to African clients, like entering therapy in order to get help or advice, would also be present in working class communities in the west.

He defined the talking versions of therapy as a culturally valued activity in the west, where modern psychotherapy had implanted itself to a level where words from a professional discipline had entered everyday conversation, indicating that people’s mentality had begun to buy into the constructs one might use in a therapy session. Described in Vygotskian terms, the zone of proximal development between a client and a therapist was not that distant. KK argued that the focus the “talking cure” was to help clients move closer to how you eventually came to understand them, attempting to build a common language and a bridge between them and you. He underlined that starting at opposite poles, however, this could take a long time, or one might not even “get off first base”. In his opinion, a therapist might need to spend time explicating the idea of talking as a way of resolving problems, almost educating the clients to the fact that spending time reflecting on their behaviour rather than “just doing”, e.g. engaging in actions, could be good for them.

Others, like DD, expressed problems with the underpinnings of psychotherapy. Speaking from a feminist perspective, she felt the patriarchal history of psychotherapy was problematic. She also expressed concern about the capitalist individualistic focus of psychotherapy and argued that psychotherapy as a model assumed certain things about people’s control over their environments and over themselves, which ignored socio-political realities for those people. She concluded:

*“I still think there’s a great deal of value in making contact with another human being in a way that has integrity and that feels real and engaged. But I guess I’m a little more cautious about how far I think that contact can assist people in whatever difficulties they’re facing. I think a psychotherapeutic intervention is useful but limited in what it does. I don’t think it can do as much as it suggests it can.”*

GG reflected that Freud called psychotherapy the “talking cure”, consequently, it should be applicable across the cultural divides. However, she said she found herself constantly

struggling with the question in therapy. Being a black, female therapist growing up under apartheid she struggled with the models provided for understanding behaviour, the language that came out of these models and the interpretations therapists might make in such a situation:

*“There might be difficulties with how people would make interpretations – something that I don’t do in the same way because I feel like some of the interpretations are so culturally jarring. There’s no way I’m saying that to my client. I’m going to find another way of talking about the same thing”*

GG addressed the prospect of there being a special kind of language that could underpin the conversations of the “talking cure”, something South African therapists would need to be aware of. HH, having worked in townships with black clients both during and after the apartheid era, addressed the same thing, though phrasing it differently:

*“Some of the parameters need to be more appreciative of cultural idioms of expression, cultural ways of understanding distress, cultural ways of resolving issues, and for therapists to be culturally aware of what these things are.”*

What they both started entering into with this response, is the discussion of the challenge of language. I will address this more closely in the following section on challenges.

The flipside of alienating western culture would be to romanticise the non-western. The therapists warned of the dangers of the idea of the community as some sort of nirvana that one should be moving toward. One could not ignore the complexity in the interplay between society and individuals, and focus on one and not the other would create a difficult position either way. DD said:

*“So I don’t go for romantic notions that before colonialism Africa had this sort of...communal Ubuntu, and suddenly it was destroyed by colonialism, I don’t buy that either. I think that there are struggles, and I certainly think that gender struggles seem to cross every boundary and exist in all societies.”*

DD referred to some of the criticism of the application of Ubuntu described in the section 1.4; the notion that one would find difficulty in attempting to restore a notion of a “pre-colonial” African grandeur, as pre-colonial Africa may also have had its problems with inequalities. All the therapists also believed it was wrong to assume that people who are white and middle class and affluent do not have psychological difficulties; that money automatically stops or prevents a person from being emotionally distressed.

### ***Psychotherapy’s culturality and therapeutic work:***

*“It influences my work in the sense that somewhere I have to abandon the western approach and use what I think will work for the people.” (LL)*

So in what ways did the dominance of western culture and standards influence therapeutic work in South Africa? The answer to this proved to vary slightly according to client population and therapist background:

BB pointed out his awareness of the fact that there were hundreds of psychotherapies, but that the “talking cure” of change in western culture required reflection and insight, whereas in some indigenous African communities it was about practicalities; “is this working or not?”. In western psychotherapy one would not give advice, because it would not be empowering to the person. BB indicated that this had influenced the way he worked because he had struggled with it. What to do when a client came asking for specific advice? According to the way these clients would have experienced help in their communities, it would be something that they would expect. LL said that one of the things that would be different would be working in settings with the extended family present. FF gave an example of this from the apartheid years where a client was worried about her child, and FF asked her to bring the child in. The session ended up involving the mother and child and 15 other people watching. FF described such situations as previously being challenging, but said it was not problematic anymore.

GG worried about the discourse around whether psychotherapy was appropriate or not in a South African context, and whether for instance community psychology was more appropriate. Sometimes they would come across as mutually exclusive and GG thought this to be erroneous, as communities comprised of individuals. She thought it important to work at multiple levels and from different angles. She illustrated it with an example from her own work:

*“I co-facilitated the Khulumani group<sup>8</sup>, we didn’t know whether it was supposed to perform a therapeutic function, but it did and was something outside anything you would read of in any book on group therapy, because it changed from week to week. We’d train once a month – and some Saturdays we’d have as many as 200 people sitting in the room and doing their story telling and so on – so it’s kind of finding creative ways of working. I sometimes would get the “what am I doing here?” feeling, but if I thought about it theoretically, it would help me make sense of everything that was happening and the feelings I would be taking home.”*

She also thought it was important when working to remember that theory was there to guide one, it did not hold the answer to everything:

*“Because for me, in as much as I’ve said I work within the object relations school of thought, I have never found that it can help me...by and of itself manage things.”*

GG’s statement was in accordance with a universalist position of thinking (Sam 2006, Berry 2002): We all experience problems. Though we might not have the same language for talking about pain, it does not mean that pain is a domain of particular cultures.

Lastly, many of the therapists also worked as researchers and lecturers, for example CC, who said that in his work as a researcher he tried to examine local contextual realities, and to be critical of Western theories and not blindly apply them in a South African context.

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<sup>8</sup> Khulumani is a community group started to help victims of apartheid and their families



#### **4.2.2 Challenges to attaining healing**

I investigated what challenges the therapists felt were encumbering healing. Apart from language, which is an aspect of its own, and beyond the scope of this dissertation, the challenges listed in the following section could be seen as targeting factors facilitating the actual therapy process. They were challenges faced outside the therapyroom, to establishing and maintaining client contact.

##### ***Conceptualisation of distress:***

One of the elements determining the way a society relates to healing is the way it conceptualises distress. Berry et al (2002) have stated: “Just as there are cultural factors involved in the development and display of psychopathology, so too are there cultural factors involved in the process of alleviating these problems” (p.437). KK focused specifically on this. He said that all cultures develop ways of dealing with distress and have done since” time in memorium”. Also, knowledge systems are evolving, not static or of one kind. Tools for healing would be shaped by the prevailing knowledge systems, the notions of distress and healing, and the notions of mind, body and spirit that prevail in those societies at those times:

*“And the modern western one is probably one of the few really, in which those three pieces are split off.”*

KK readdressed the individualism that underlies western psychology, and the challenge it brought when working with the interior mind rather than the tri-partae bits of body soul and mind. He also said that there are culture-bound ways of expressing distress. Umumfuyana is a classic example of such a syndrome and is supposedly particular to young women within the Xhosa society.

##### ***Language:***

All the therapists mentioned this challenge as the most basic one. A compatible language base is essential in therapy, as the talking cure seeks healing through conversation. South Africa had eleven official languages, and fourteen years after the abolition of apartheid still had very few African language therapists. The alternative to having a native language speaking therapist was the use of interpreters. The white, coloured and Asian therapists were particularly focused on this challenge, as the black African therapists had trained in English and had an advantage from speaking at least one of the African languages. FF listed language and translation issues as a particular interest and said he felt they were under theorized. KK also described working therapeutically with interpreters as very hard:

*“One can get some of the way down the line, but if you don’t know what on earth is transpiring between your interpreter and your client – it’s a bit spooky.”*

FF and CC said they thought it imperative for therapists to learn languages beyond the language they were comfortable with. They argued that knowledge of a language and the way the language was built would also give a different perspective of the related worldview. FF believed there were a lot of excuses made about culture when people actually should be learning languages, as a better cultural understanding would follow. Even if the outcome was not being able to speak the language, for the competence of understanding the client's worldview, therapists should try.<sup>9</sup>

However, simply speaking the same language was not the only language related challenge. Metaphors and idioms of expression were related to the challenge of language, but more difficult to grasp. One could maybe call it the idiom that goes with language, an important factor in therapy. CC believed there would be challenges both in trying to understand what the client was saying, and also ensuring that the meaning conveyed was the same he was receiving. Another part of this concerned what words were used to describe psychological pain. KK pointed out that often there might not even be a linguistic equivalent for the word:

*"Is there a word for panic? Is there a word for depression? And if so, does that mean it has conceptual equivalents to what I think depression is? And that's not always the case."*

Turning to the idioms of distress, the informants addressed whether idioms of distress were different across cultures. DD agreed that there may be ways in which expressing distress might be more acceptable in different societal systems. A challenge would be figuring out which one was specific to the group of people one was working with. HH said there existed loads of explanatory models of what distresses people, and a challenge for psychotherapy was to be appreciative of those idioms of expression. He gave the example of people attributing distress to witchcraft or ancestors. He believed psychotherapy had to enlist that understanding. The dangers to therapy if one was not open to exploring and understanding a culture's different idioms of expression, was pointed out by BB. He warned that there was a language or discourse that psychotherapy, as presented in the West, expected you to have. To be considered a "valid client" one had to learn to "speak the therapeutic language". Not knowing this idiom could lead to not receiving sufficient help. KK gave an example:

*"I know work a friend of mine used to do in Cambodia where people in the displaced camps in Thailand did not understand that when women gave birth, the placenta had to be buried in the vicinity under a tree of a certain kind, otherwise it would disturb the spiritual realm. These women were sitting there having given birth, and they would report terrible pain in their heads and talk about it as this "great, big, black bird hacking away at my head with a big beak on" and nobody knew what the hell was going on. And it took time to draw up a DSM for the Khmer with pictures, with words, with everything, so that one could begin to understand a little better their cosmology and how that translated into their symptomatology."*

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<sup>9</sup> For a closer look at challenges facing psychotherapeutic work with interpreters, see Svela (2007)

**Poverty:**

CC responded that he did not think western techniques were a problem. He argued that a lot of the challenges were systemic problems of poverty and marginalisation. Trying to send a psychologist to “fix” the individual might not be the best way to proceed, to his mind. He referred to a study where they tried to find out what would be the barriers to implementing different types of treatment. They found the issue was not the techniques; the problem was for people to get to therapy. This was an experience recognised by all my informants. South Africa grappled with major issues of poverty. Affecting every part of society, it also prevented people in need from seeking treatment. CC illustrated the problems of finance: A private therapy session would cost approximately 300 Rand, a little over 300 Norwegian kroner. Paying this amount of money was out of the question, but even reaching the places that offered free treatment could be impossible as free places to seek therapy were located far away. Living in Khayelitsha, one of South Africa’s many townships, minibusfare, the absolute cheapest way of transport, would cost approximately 20 Rand, which was more than they had. Therapeutically, this presented very real problems of framework and prevented more traditional therapeutic work. FF said trying to create a sustained process in a more conventional sort of psychotherapy relationship was very difficult, and no “one session fixes everything” model existed. DD worked with women, and to them an additional challenge was a lack of power. Working with rape survivors, she said the rape itself was usually horrific, but the contexts in which they lived were also shocking. She said in this context, she felt her “whiteness” acutely. She felt being white and middle class put a barrier between her and the survivor. Added to the challenge was that she met these women only briefly, leaving no time to build a sense of a relationship or to break through the stereotypes that both held about each other. Another aspect she raised was how useful therapy was for these women. There was rarely any counselling or debriefing after rapes, and if there was, it was not what women asked for. She said:

*“That’s not to say that I think a woman who has been beaten in her partnership or has been raped or assaulted is not in need of speaking to someone who is empathic and thoughtful about what impact that’s had on her. But I’m pretty sure I’m going to find too, that the reason she became vulnerable to that kind of assault or attack, is going to have socioeconomic underpinnings. And then I think we’re a bit challenged in terms of where to go from there.”*

**Therapy culture:**

The therapists also reflected on whether there existed a culture for going to therapy in South Africa. CC pointed out that there were many reasons why there should not be, like the fact that people’s contact with the health system largely was a negative one. At public health

clinics one risked standing in long lines and experiencing abuse from medical personnel. This alienated people from the health system in general. FF reflected:

*“I think some of it has to do with cultural assumptions, but they’re not non-western cultural assumptions, it’s more a learned process. If your experience of a health system is to get up at 03 o’clock in the morning, go wait in a queue, see a person for 5 minutes who doesn’t look at you or talk to you, and to never see the same person twice, what will be your expectation of a psychotherapist? It is going to be the same. And then the slower rules of politeness which are quite common in many societies, and are very prominent here, don’t apply in health settings because they haven’t got time there, which affects clients. So it doesn’t mean that they are less sophisticated or unable to talk about themselves.”*

Another connected issue was stigma. Mental illness and psychological disorders were considered reprehensible. Many people would not want to admit that they had a psychological or psychiatric problem, hence feeling inhibited to seek treatment. FF argued that as a white, male therapist, it was hard to imagine the circumstances under which most South Africans lived. He gave an example of how poverty and stigma could make life with mental illness in South Africa gruelling. Communities in South Africa paid for water, something not normally considered a mental health issue. The findings from his study however, showed that suffering from schizophrenia and living in a poor area, there was a huge stigma of mental illness: Patients took their medication resulting in dryness of the mouth. However, they had no water as their families could not afford it, resulting in clients walking door to door in the neighbourhood saying “please give me some water”, resulting in further stigmatisation. FF concluded:

*“It’s obvious when you thought of it, but I mean...who would have thought? So there’s this kind of unimaginability”*

He said that in his context, one of the biggest challenges was understanding that there was some value to be had in containment or listening and being appropriately attuned to people, without requiring a change in people’s life circumstances. In a society like South Africa, that could be a real challenge. The danger, to his mind, was submitting to a misunderstood idea of a Maslow needs hierarchy implying that “luxury is like the internal world: it’s only for white people”. However, addressing the reality of South African society, how does one give psychotherapy an appropriate place instead of “running in with psychotherapy when people want a blanket and a roof over their heads”?

***“For me, putting a roof on somebody’s head is a psychological intervention actually”***

KK asked the question that some of the therapists had touched upon: where did psychotherapy fit in a context of poverty, what role did it play? He said it was obvious psychotherapy had a critical role for people at the “top end of the pyramid” but the challenges faced by most South Africans were serious basic life issues. An alternative could be community psychology. KK said that the broader idea of community psychology entailed helping communities to mobilize

as political entities to improve their situation. In some ways contradicting HH, who said that psychology should no longer be liberationist, KK on the contrary, asked what role psychology could play in political activism. He said that the community psychology movement, before being swallowed up by bourgeois psychology, was quite progressive, helping to build social capital in dysfunctional neighbourhoods using psychological knowledge and theory. He said:

*“And they’re psychological interventions. For me, putting a roof on somebody’s head is a psychological intervention actually.”*

### **Spirituality:**

The therapists all brought up one aspect that neither of them believed were specific to the South African context, but rather an insufficiency in psychotherapeutic practice in general: the aspect of spirituality, or, as it were, its absence in psychotherapy. In my sample, there was a unison opinion, regardless of therapist background, that one of the things psychotherapy tended to ignore was religion, the discipline assumes that people will keep this aspect separate. DD believed that in western contexts as well as in South Africa, this actually keeps people out of therapy. KK argued that the Cartesian approach common to western psychology was problematic, making it a cognitive environment, rather than a spiritual and cosmological one.

HH argued that looking around the world, people believe in God, a spiritual world, an afterlife. GG expressed a devout Christian belief, but said that she was always careful to keep this aspect out of therapy, even when clients shared her faith. HH reflected that psychotherapy was a materialist, determinist model of understanding. A challenge then, was to bring the spiritual aspect into therapy. HH argued that how a therapist addressed a client who explained causality as God’s will, would be equally demanding to that of a client placing causation with ancestors.

*“In fact there’s a whole development of a thing called Christian psychotherapy, as people feel psychotherapy leaves those with a spiritual base stranded. It’s almost like another culture in a sense. I knew of this couple whose infant boy died. They never went to therapy and the way they got through the first two years, is they prayed. I thought it was a bit of a defence against the grief, but two years later they emerged from it with a sense that it was God’s will and they forgave God for doing this. Who am I to argue??? I think they didn’t go through any post traumatic stress. It is very interesting for me.”*

DD found belief systems difficult in a different way, and dealt with the opposite problem to GG, as she said she did not consider herself to be religious. She claimed that religion was a cultural group. And according DD, there were a lot of very strong Christian beliefs held by African people in South Africa which had meaning in terms of what to do about a particular problem:

*“For someone who’s deeply religious in a Christian faith, and is in an unhappy and violent marriage, the church may have a very strong position on women leaving that system. And it’s*

*really not useful to try and ignore that just because it's an uncomfortable position. As a feminist it's hard for me sometimes to hear those positions but they're real. So I have to engage strongly with what that might mean. And sometimes I'm a bit flummoxed myself, and I'm not sure that I know, but I don't think that pretending that it doesn't exist is there."*

Many of these challenges, which informants listed as their primary concerns, were challenges to essential parts of a psychotherapeutic framework. These challenges being so prominent was an unforeseen finding. If one compares psychotherapy, by way of using a metaphor, to an "operation of the soul", the psychotherapists' counterpart would be the surgeon. Now there are certain accessories that a surgeon could not be without, if she were to perform a successful operation. Similarly, some of the psychotherapeutic frames are there to ensure the therapists have an appropriate working ground to facilitate healing. Some of the therapists questioned the role of psychotherapy in a society struggling with overwhelming challenges to these frames, but nevertheless like FF, believed there was value in containing and in listening.

#### **4.3 Cultural African elements that influence psychotherapeutic work**

##### ***There is no one Africa***

HH made the point that there is no *one* Africa. There were two relevant dimensions to this statement; the basic one that Africa is a diverse continent and should be treated as such. The other one was related to the South African context where people carry multiple identities as the norm, not the exception. DD said people pick and choose from the different identities available to them and create their own. The same available choices would not produce the same blend in two different individuals. She believed the relation between the traditional and the western was also "a muddle for the person sitting opposite" the therapist, emphasizing, as LL did, the importance of exploring individual worldviews when working with African clients. The clients all brought in multiple identities; which one took precedence over the others at any given time or situation? This would vary, both from individual to individual, and often also within each individual in different phases of the lifespan. Therapists would need to ask the clients and acquire some idea of where they placed themselves. Was their Xhosa identity more important to them than being black African, or was this a political position more defining than language group? She said that the racial category "coloured" was an illustrative example in South Africa. Did a coloured person call himself African, black or coloured? Any of those positions indicated a political position. Before investigating this particular client, one could not be sure what it indicated. She also believed precedence changed according to where an individual was in his lifephase: being a teenager, things had a different meaning to when in ones thirties. DD underlined that such an exploration would not be exclusive for working with diversity, but aspects she would want to know of any client, and she found it problematic that

therapists did not explore them with people they assumed sameness with. She believed one often assumed sameness based on same race, class or gender, an assumption that could land therapists in difficult water realising there were big differences. KK said that in any society there will be a predominant tool for healing, but also variation. Just like within a modern community people go to a psychiatrist, shamans, the GP or to church. To talk about African healing was “a joke” in his opinion, due to the complexities of the African context.

All this being said, certain aspects are, in fact, similar and particular to African culture sub Sahara and to South Africa post-apartheid, which will be explored more thoroughly through the therapists’ answers.

#### **4.3.1 Challenges to therapy**

At some point, the therapists moved from challenges keeping patients out of the therapy room to those taking place inside it. The challenges listed to the therapeutic relation or the therapy process, were more infused by issues of culture. LL said that if one were to make therapy relevant in an African setting, one would bring in aspects that might, to western therapists, come across as big challenges; the aspect of the African’s tendency towards wanting to restore harmony in families at all cost, the respect for elders, the unwillingness to divulge information to strangers. BB listed the main challenge to be creating a space where clients could understand their world view and their distress in terms of the African context and experience. He again used the example of spirituality; to allow room for the use of spirits to explain and cause things, and also for rituals that needed to be performed. In his opinion as long as therapists were aware of the fact that these aspects of African culture was incorporated into the person’s world view, applying psychotherapy would not necessarily be a challenge, the two could exist side by side. For example a medical doctor trained in the west would still go and see traditional healers without seeing any conflict. On the other hand, if a psychotherapist were not acquainted with the African way, BB said this would definitely be a challenge.

#### ***Psychotherapeutic framework:***

Western psychotherapy has a framework that prescribes adherence to a certain set of rules guiding the therapeutic relationship. In certain schools, strict adherence to such rules are seen to be crucial to provide progress in therapy. In a South African setting this presented a challenge. BB explained that indigenously in Africa there was a different philosophy:

*“Let me give you an example from my experience: a group therapy where the whole focus was “express your feelings” you know? And that’s not necessarily something that I or people where I come from do...in that sense where I say: “right now I’m feeling quite hurt and pained”, it’s*

*not like that. Because people's approach to life is; one: relationships and two: it is practical. Does this work or doesn't it? Does it help or doesn't it?"*

Another challenge he said, was to the professionalism of psychotherapy. In an African traditional setting, help or healing was sought through a shared experience. I asked BB about therapeutic sharing: as a therapist, you are also supposed, to an extent, to share. Would he say, then, that these are different forms of sharing?

*"It is exactly that – different forms of sharing. And it is not sharing only in one time and space, but in continuous interaction. I would see how you live, your life would speak for itself, and normally what would initiate the contact would be precisely that. So it is not just that we meet in this time and space by appointment, there's interaction outside the therapy."*

### **Boundaries:**

One specific aspect of the psychotherapeutic framework that presented a challenge in the South African setting was the notion of boundaries. DD said in South Africa, therapists' boundaries seemed to be challenged, for example if the therapist lived in the context within which they came across people in distress. People would ring the doorbell when there was a problem, and because people's needs were so pressing and multiple, being "the person who helped" would imply being asked to help on all levels. BB recounted his situation in Malawi, being the only practising psychologist in the whole city. There would be issues of boundaries, because therapist and client would meet for example in church. In therapy there were certain personal questions BB would not entertain in order to maintain the boundaries, but in a different social context, it would overlap thus presenting a challenge.

GG thought therapists were afraid to adjust because of a fear of deviating from a western standard:

*"In our quest to be exactly like the West we hold on to things too rigidly, like the issue of boundaries: therapists would say "Oh I can't be in the supervision group with this therapist because her friend's daughter goes to the same play school as my daughter". And they flip out because they run into their clients at their morning stop, and I'm thinking "just find a way of working with it."*

KK told a story that related to many of the issues regarding psychotherapeutic framework and boundaries:

*"One of the most difficult and interesting cases I had was a white woman in the liberation movement whom I saw for quite a long time. I never knew whether she was being paranoid or real, because she wouldn't, after a while, do therapy in our office, we had to go and sit on the mountainside behind the university because she said the office was bugged...and quite possibly it was bugged, I don't know. The challenge for me was to know how to deal with her paranoia and her tendency to split, which was real, and the reality of the political situation within which paranoia was healthy. Those times I had to unlearn a lot of the rules of therapeutic practice, like I would go and do family work in somebody's sitting room. They wouldn't come to my office. It was too dangerous...so all the things you're supposed to do or not do, getting to know people more intimately and so on, under those conditions had to be bent. For better or for worse, and that taught me a lot."*

### **Focus on the individual:**



The therapists all touched upon the individualist-collectivist axis in some way. JJ said she saw it as a challenge that Western models largely focused on the individual as both the source of the problem as well as the source of the solution. In her opinion, the locus of control, the locus of evaluation and the locus of change was the individual, something she found problematic, as it largely ignores how contextual factors can contribute to psychological distress. KK believed that the important thing for people who grew up in collectivist societies was the affiliative bonds. He believed a piece of self was connected to a set of obligations to the community and that there would be conflicting desires and needs in the individual with regards to self actualisation versus adhering to a set of strong affiliative patterns, something that would affect therapy. CC believed the emphasis on individualism in western theory affected the psychotherapeutic profession on the theoretical level. While there existed a wide variety of western psychological theories, he believed there was not a lot of theoretical work on indigenous psychology in South Africa, something he considered a weakness. He also criticised the fact that South African therapists were good at calling attention to the pitfalls of applying psychoanalysis, or cognitive theory to South Africans, but less good at attempting to formulate and develop theories that were indigenous. He concluded:

*“The concept of Ubuntu is an interesting one and how that might, at some point, form the basis of a home grown theoretical framework.”*

### ***African psychotherapy theory***

What CC expressed was that there was a lack of literature on how to work therapeutically in an African cultural setting. LL saw the biggest challenge in the fact that literature focused mainly on western culture. This left a challenge for African psychologists to create such literature. GG sensed a kind of resistance from the discipline:

*“I don’t know what it is about South Africa, it’s almost like – you know; we have to do things like this because this is what all the textbooks say.”*

Finding literature on African psychotherapy written by African scholars in Africa to inform this study proved to be a difficult undertaking. In comparison, much literature existed on psychotherapy and Latin American or Asian culture. Arriving in South Africa for my datacollection, I assumed, then, that not much literature existed. FF said:

*“I completely disagree with you. There are theses and articles and books written and they all say the same thing: “there’s nothing written about it and I’m the first one to write it. It’s been going on for 30 years. So (laughs) we sort of reproduce the idea that there’s nothing written which is actually not the truth.”*

He said that proportionately, however, Africa did not have the same scholarly tradition as in Asia or Latin America. Another quandary was that the literature that did exist was not available to the west, and sometimes not even in South Africa. This created a stagnant research process, with scholars unable to build on each other’s work, and rather ending up

reproducing the same work. Madu (2003) argued that psychotherapeutic activities in Africa have not been sufficiently and efficiently documented and published, and listed various reasons for this. He also said that if such documentation was written up, it would often end up as monographs in individual bookshelves.

### ***Ancestors***

HH said that to his mind there was a worldview in African black South Africa about the role of ancestors and how psychological stress could be a product of disappointing your ancestors. Also, there was the understanding of people being able to do things to each other through witchcraft or voodoo, or wishing illness on another or casting spells. Closely related to this was the issue of explanatory models of causality being personal in African culture. In the western medical model, if someone suffered from cancer, one would call it tough luck or attribute it to smoking or stress or *something*, whereas in African culture one might superimpose a *personal* causality: “it’s because you let your ancestors down”. The challenge lay in accommodating this causal system in models of working with African blacks, particularly in rural areas. The third challenge, HH limited to rural cultures; People’s understanding of physical causes was limited: a seizure would be attributed to spirits, but the person might suffer from an epileptic disorder.

### ***Community based models of healing***

Additionally, there was no culture for individual private therapy, but rather community or group based modes of resolution to distress and healing through doing – actively doing certain things to solve the distress rather than think about it in a psychological sense.

CC said during the struggle years and the role of the ancestors became important in a political context. Rituals played an important therapeutic role that should not be glossed over, but accepted and embraced. The acts of planting a tree or burying a body were therapeutic phenomena. In the Struggle, funerals played an important role at various levels, a psychological phenomenon in helping people grieve. It was also a political phenomenon, because it would be an occasion to say “These people die unjustly”.

BB responded that to his mind, it was the practice of psychotherapy as a discipline that was culturally determined, its structure with a professional you pay to talk to you and to facilitate healing. BB explained that in Africa there were many ways of achieving the same thing that you get from psychotherapy. I asked him to elaborate and he explained that during a person’s lifecycle one arrived at certain stages, where one would sit down and be advised a priori. Before main events, like marriage and childbirth, there would be an elder sitting down and

advising the couple. If there were specific problems, there would also be a forum, but its main objective would differ slightly from the one of individual therapy:

*“If there is conflict, like “your goat walked over my field”, you go to the chief and that person deals with those issues to resolve the dispute. The aim, the objective being to restore harmony in the relationships which is a primary thing. It is not about making you feel better and stronger and empowered and so on; it is about restoring harmony in relationships, in the community.”*

HH also made a point of the fact that there are healing variants in all cultural groups, though they might not necessarily be *psychotherapy*, but it is important to keep in mind that there are a lot of overlaps in what constitutes healing practises:<sup>10</sup>

*“We used to run groups in the hospital for what we then called the black patients, like drumming groups, dance healing and conversation. And you know, they were therapy, grouptherapy. But they had all sorts of other indigenous components to the practice.”*

***“Get over it and get on with life”***

GG challenged the position *psychotherapy* holds in Africa more extensively, saying that in Africa *psychotherapy* is not a norm or “the usual thing”. Previously working as a nurse, she came across people who had suffered gross violations, such as children who had been raped. She said that one of the reasons she decided to study psychology was the sense that there was no space for mourning. Things happened and you were expected to get over it. After a rape, the victim could hear “come on, most of us have been raped, get over it and get on with life”. That was the norm. You mourn if you have to mourn and then you go on with life. GG also spoke about the role of rituals and their value. Most of the African cultures had an array of rituals, for example around loss and death. The funeral consisted of a week of mourning with the whole family, a cleansing ceremony a month later and another ceremony six months or a year later. She believed rituals helped one deal with things, after which one is expected to move on. GG explained that when somebody has died, you cannot cry for too long as this will hinder their path into the afterworld. To help get through it, there is a shared mourning with the different rituals as a connecting factor. Similarly, KK told a story about child soldiers from Mozambique:

*“In Mozambique years ago play-therapy clinics were set up in the bush for former child soldiers and I was working there at the time. We were asked about the fact that people didn’t send their children to the clinic. They’d spent a lot of money on this, trained local people as sort of lay therapists and such in play therapy and all that, but they hadn’t asked the local people what they did with children who come back from the war. The locals said they went through a series of ceremonies, but once that was done, if you talk about it again then the spirit will enter you and poison your soul. So you had to be a right idiot to send your kid to that clinic once they had been through the cleansing ritual. The nagging thing still remained that we knew damn well that there were kids who’d been through all that stuff and they were still troubled.”*

The challenge that KK touched upon with the child soldiers, GG also described: if one finally got people in therapy, one would find that there were aftermaths and consequences. GG said

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<sup>10</sup> See section on Ubuntu

that in her work, particularly with abused clients, she has had to be careful in using therapy theory and understanding when working with these crossover situations. It has been very important not to devalue a traditional way of working through trauma or other problems and to explicitly show that one respected how clients have dealt with it and are managing, rather than denigrating it, diagnosing it for example as dissociation. Though psychotherapy has not been the norm, GG said that more black people currently attend therapy. She believed there was a dawning shift in attitudes towards seeing psychotherapists, where therapy was less associated with stigma and “mad people” and more introduced into the dialogue.

#### ***4.3.2 Addressing the impact of apartheid***

At the time of the datacollection, 12 years had passed since the abolition of apartheid in South Africa. Moving into an era of democracy, making permeating changes to the social order would be reflected in almost all areas of a society. My supposition was that working in the area of human behaviour, such changes would affect psychology as a profession. I was also under the impression that some of the issues, like racism, had changed from being overt to taking a more subtle, covert form. I hypothesised that this would be reflected in the therapeutic setting. The therapists addressed challenges specific to the aftermath of apartheid.

GG addressed the consequence of apartheid for the therapist population and said that even with equity laws, generally the profession is dominated by white therapists, perpetuating a particular way of thinking, namely that long term individual psychodynamic work was “the only way” to work, and she sensed an unwillingness to go beyond that. Post-apartheid it has been a specific commitment to train black students. HH explained that a lot of the black students struggled because of the poor language background in English which was still the language of education. As a training therapist and lecturer he said he worried about imposing both language and models. One needed to allow a young, black South African to say “This is the way I choose to do it” and to sit back a little bit and say “OK, well, you shape it then”. All the therapists agreed that the issue was more complex than it might seem. In becoming clinicians, students were often moving into a new social class, which affected identity. Literature exploring the experience of being black, transitioning and being seen as belonging to a different class, found that therapists were being drawn between their different loyalties. Van Dyk&Nefale (2005) have called it a split-ego experience, Kottler&Swartz described the clinical training of African therapist in terms of a rite of passage where they literally pass over from one worldview to another. Kometsi (1999; 2001) described experiences of how the

African therapist can feel shame and other counter-transferential emotions in multi-racial clinical settings.

HH said working with people in South Africa, depending on their age, the concept of what impact apartheid or living in apartheid has had on their life would be a challenge. Was there any credibility as a white person to speak to people who are not from a white background around these issues? The credibility would be much more difficult to even negotiate. He said there was also variation; some clients felt apartheid had blighted their lives, for others the effect was more distant. The therapist might abstractly say “OK, they’re third generation and they’re not living well, they’re poor because of the structural effects of apartheid” but clients would never bring it up while others would continuously, feeling that it had crippled their lives.

### ***“The hypervigilance of the oppressed”***

KK directly reflected on racism, certain to be a topic in many South African therapies. Firstly he addressed his own, that is therapist projections about people, saying they used to have racially mixed supervision groups during the struggle years, to talk about “how are the whities dealing with their projections about black people”? At the same time he said, a very difficult thing to talk about, but nevertheless an issue, was the hypervigilance of the oppressed; black people’s fantasies about white people’s racism, which was equally real. Somebody being brutalised by the system, is going to be hypervigilant with a white therapist. FF argued that such suspicions were natural, even healthy. But as KK argued, sometimes therapy fell apart from those doubts. They could not get past “how can I trust you? You’re a whitie”. KK said that in the Struggle years, the only way one got past hypervigilance was to declare one’s political position. This led to therapists not being neutral in the therapeutic process, ordinarily seen to be an important aspect in therapy. However it was the only way of crossing that bridge of apartheid as a white therapist. He believed it remained present and that the countertransference and the transference in a racially divided and oppressive society was an issue.

### ***To be “good enough”, the challenge of living up to the Western golden standard***

Sam (2006) said that the western way of human behaviour had been seen as a “golden standard” by which one would measure the rest of the world. This had implications for psychotherapeutic work in South Africa, especially for black therapists. GG said that South African therapists needed to give up the idealisation of the north:

*“There’s the issue of the profession’s relationship to Britain and Europe. This is always discussed; how we’ve always felt like the grandchildren of the theories, you know, like we’re*

*on the periphery and so we have to do things well and that probably feeds into this thing about having to be **good enough**. And being “good enough” means you don’t deviate too much, but prove we can do this in a way that’s similar to yours in order to be seen as being as good as you are. But that doesn’t mean we have to do things **exactly** the same. You can’t just transport things as is.”*

GG’s response conveys an insight into how the collective African inferiority complex has been particularly accentuated in South Africa as part of the apartheid system ideology. Instead of valuing and discussing the development of a culture-appropriate psychotherapy, being creative and adapting to your own setting would be seen as not upholding a certain standard. To be “good enough” entailed not deviating from the norm.

#### **4.3.3 Psychotherapy post-apartheid**

JJ said that even though there have been changes on the surface, South Africa still had huge issues around race, and in her opinion disparities have grown even more. She said that in terms of suffering or distress, the needs in South Africa had increased post-apartheid. Additionally, South Africa was still feeling the effects race and apartheid; just because the legalised form was gone did not mean that racism did not exist. FF also said he thought the South African people were disappointed, post-apartheid. A piece of this disappointment he placed on the public’s expectations being unrealistic. He believed South Africans lived with the illusion that their situation was unique, part of what facilitated the transition to democracy. FF expressed the opinion that it was not a unique situation, having visited for example Latin America. In the aftermath of apartheid, illusions were crushed with the post-apartheid struggles to rebuild the country. He believed South Africa had a political problem also manifesting as a personal problem at a range of levels, which was that decisions were still made on the basis of very narrowly understood apartheid created identities, rather than on the basis of conviction and argument. FF believed these issues affected psychotherapy, its praxis and reputation.

DD said if she did not live in South Africa, her psychotherapeutic practice would be different. She seriously engaged with and was challenged by the South African history and the continuing inequity. She said she felt limited as a white South African, but that in her opinion there were “times where we should and shut up and let conversations happen without our big mouths”. She offered the Zuma rape trial as an example<sup>11</sup>, and said that though painful to watch, it was extraordinary to hear black women argue their positions and speak for

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<sup>11</sup> At the time of my datacollection (2006), the politician Jacob Zuma was on trial charged with raping a woman he considered to be his daughter, knowing she was HIV positive and not wearing protection. Zuma was one of the freedom fighters, and people were shocked by the trial as well as some of his statements connected to it. He also had pending charges of corruption. Zuma was acquitted on the rape charges and is currently (2008) the newly instated leader of the African National Congress, South Africa’s leading political party.

themselves. Pumla Gobodo-Madikizela, a black psychologist who was a member of the TRC committee, wrote some editorials and commentaries connected to the case. She believed that Gobodo-Madikizela could say certain things that she, being white, should not say. In this DD touched on the issue of white people's feeling of inadequacy. While black therapists struggled with feelings of "not being good enough" for a western "gold standard", referred to as the black inferiority complex (Duckert, personal correspondence, 2008), the white therapists post-apartheid dealt with the collective shame (Krog, 1998) and an inadequacy in relation to their black clients and the reshaping of South African society. DD said that she sometimes felt she did not have an enormous role to play in the new South Africa. FF said he did not feel that way at all. Rather, as new voices emerged, he felt less constrained to have to be quiet. He did not feel so much like a power minority or ruling class member walking into a room anymore.

***"One keeps working with people's despair"***

Another thing emphasized by the post-apartheid changes, was that therapists worked more community oriented than individually. HH spoke about his work as a therapist saying that already as a student he worked in townships and 25 years later he was still working in townships:

*"And they're **poor**; they were poor then and they're **still** poor. And in **some** ways I despair because I saw children then and I see children now who are properly, and that is the world one lives in and works in. I don't work in an affluent area; my world isn't involved in that. So it can be very demoralising, where you wonder what's the **relevance** of psychology in contexts of poverty? In the old days they used to talk about psychology's going to liberate people and help fight oppression and so on – these are nice **ideas**, but when people – like this morning they had an intern in here and the woman she is seeing is unemployed and lives under a plastic top pollen in Stellenbosch on the side of the road. She came here to the public clinic.....(draws audible breath)...it shouldn't **be** like that, you see. It's **despairing**. And it's OK if you deal with it for one year, but to deal with it for **twenty** years of your life, it can wear you down at the knuckles, and you get to a point where it's very **hard** to see the **role** of psychology often in an overwhelming face of socio-economic factors which should really be resolved before psychology in this case here. A cognitive behavioural therapy mode that tells someone that they've got cognitive distortions, I **can't** do it when the **environment** – the **context** is distorted and the majority of people are poor. These are the things that I think are very, very difficult. You know in Norway, the safety net is **assumed**, and then you work with that platform. There's no platform here. That's it – that's true in Africa."*

LL on the other hand believed psychology had become more relevant post-apartheid, unlike previously where professionals could see what was happening in the country with the oppression and its impact on human rights without saying anything. After the transition, however, she was of the opinion that psychologists could speak up and address the impact apartheid had on people and helping accordingly.

***"Racism hurts!!"***

GG said that the kind of clients she was seeing were young, black women willing to engage in psychotherapy for growth. However, the issues they brought to therapy got overlaid with race. GG said the younger generation of black women were shocked by racist practices. Most of them grew up when the society was moving towards an egalitarian society and had never thought of being black as an issue. GG explained that when these women moved into the jobmarket, they were flattened by the racist practices at their workplaces. GG divulged that initially, part of her thought: “Why are you crying? What did you expect?” But in thinking this she had to check herself, as such experiences were outside any norm one should accept:

*“**Racism hurts** – it actually hurts people. I mean I’ve seen some of these kids come to my office and not even sit in a chair and just crumble on the floor and weep, maybe because it’s so unexpected. Something I’m seeing in my work in South Africa is that the racism is not that overt anymore. The **covert**, the subtle racism is difficult, it’s **deadly**. This is what I hate about this whole thing, it’s just this racist stuff that’s coming up all the time – it’s **never** open, maybe when it’s open it’s easier to talk about, but when it’s kind of underneath... - I don’t know what it’s like in Norway, but it’s kind of these **undertones** - and you’re never sure what you’re dealing with, but **know** there’s something weird and **wrong** going on here and you can’t **name** it, you can’t...aaaaachh!!!!”*

#### **4.3.4 Integration versus co-existence**

Therapists and researchers have wanted a more African based psychotherapy. The concept of African humanity and interconnectedness expressed as Ubuntu provides a philosophy to inform such a development (Bandawe, 2005). The other question is to what extent one should be informed by other traditions or modes of healing? In the effort to create a more appropriate version of the “talking cure”, to what extent do we merge psychotherapy and other tools for healing? This is a question of developing integrationist models or having traditional healing co-exist as a separate model for healing to psychotherapy. Fisch (2001) gives an overview of different perspectives regarding psychotherapy integration, a running debate that goes far beyond the arena of cross-cultural psychotherapy. Van dyk and Nefale (2006) proposes an alternative psychotherapy called Ubuntu therapy, based on the Ubuntu concept and aimed at making psychotherapeutic work in Africa more contextualised. My informants were split in their opinions of this and the degree to which they considered integrative models useful.

#### ***A template***

BB said he was aware of the integrationist models of African psychotherapy. He believed coming up with such cultural appropriate models was the main challenge South African therapists had. However, being trained in the Western model, he took that as his template and adjusted it, but did not have other templates, for instance an indigenous African model to adapt to the Western model. However, he said he does incorporate, especially the spiritual dimension, but only when clients embrace that aspect. CC was one of the therapists who



mentioned Ubuntu at an earlier point. When asked if it was something that he would acquire knowledge about and incorporate into the way he deals with psychotherapy, he said that a superficial understanding tends not to work very well and tends not to be very respectful.

***“Well, no, because I don’t want to do it”***

GG was African black, and told me she grew up with traditional beliefs and that, in fact, her father was a traditional healer. But though familiar with these forms of healing, because of her own personal journey and her belief system, she did not believe in it. Her father being a traditional healer, made it personal she said, and she did not want to know what it was like to incorporate it. She accentuated that the training was a long lasting undertaking, and that it was a different framework of understanding people. She asked the question “why traditional healing?” and placed it parallel to the relation between the profession of a medical doctor compared to psychotherapy. But again, she reflected:

*“I’m saying that from a sort of lazar position of knowing what it is, what it is that I’m objecting to. I’m familiar with the culture and my own father was a traditional healer and so whatever respect or disrespect I have for it comes from my own experience.”*

She also said if she does not tell people to pray and accept Jesus Christ as their saviour, neither would she tell them to go to a traditional healer. However, she underlined that her opinions would not affect the clients. For GG as for many of the other therapists, the important thing was the meaning it had for the individual, even though she herself might not see it as important. If a client brought in a traditional worldview, she would work within that frame of understanding and refer the client to a traditional healer if needed.

### ***A systematic approach***

FF believed this to be the most pertinent and difficult question with regards to psychotherapy and traditional healing in an African context, and said he did not really know how to answer it. He said everyone was currently asking it, but that it had not been answered yet, although many would claim credit for having done so. He addressed the fact that if one looked psychotherapy research, the consistent finding across modalities, was that the quality of the relationship between the psychotherapist and the client was a major predictor of change. Even in the process of redoing evidencebased and manualised treatments, different procedures were being described, but attempting to isolate the active ingredient, it often proved to be the relationship. FF revealed that a massive debate existed about this. As a supervisor, FF said he had read numerous theses which declared that “training psychologists must know of traditional healing and be able to work with it”. FF sought a systematic, scientific approach to this, as to his knowledge nobody had yet looked at it systematically, but rather people proclaimed it as a kind of a value. In South Africa, many of these crossover or integrationist

approaches were performances of identity of a particular kind, he claimed. Before making a decision of integration, one would need to explore the approach and inquire as to whether it was performed across the board, by white South Africans and black South Africans alike and if it made a valid therapeutic difference.

### ***Being a witness***

DD's initial response was that it is not a good idea for therapists to incorporate alternative healing unless they themselves have integrity in relation to them. To engage in a ritual with a client or otherwise incorporate elements from a healing system she was uncertain about what represented, would be problematic for her. However, she addressed the levels of involvement a client might desire a therapist to have. She said to her, the aspect of boundaries was an issue she thought western models of psychotherapy were confused by. If a client asked the therapist to attend a wedding or a father died and the therapist was requested to be at the funeral, there would be a difference to what that meant to different clients. She also argued that there should not be a blanket answer to whether one should attend on such a request; that there should not be a negative response "just because psychotherapy principles say no". Rather, it was a question of negotiating what an attendance or non-attendance would mean. She understood that often the importance lay in being a witness to something, and the boundaries would still be kept intact. Her conclusion was that she was open to considering these issues, but focused on what they meant to therapy. In terms of therapist identity, she would also assure that she would still hold an integrity in relation to her own beliefs about what does and does not help clients.

### ***"It's just like if you say in Norway, the leaves will turn yellow in autumn."***

LL explained the relationship between traditional healing and psychotherapy: She said that as a therapist, you cannot include what a sangoma does as it is too specialised. And unlike with psychotherapy, becoming a sangoma is not a choice, it is a vocation they are called to do. They are chosen. As a therapist, one could recognise that people saw a sangoma and their beliefs about what a sangoma could do for them. As to practicing traditional healing, one could not do it as a psychologist. To her, she explained, a sangoma and a psychologist are parallel, they are both healers. She moved on to say that she did not need to collaborate with a sangoma the way a white therapist might, due to her background. At this point, I asked her if this was due to knowledge she possessed, utilising the word "inherent" knowledge. She corrected me, saying that it was not inherent; rather, it was there in the African environment:

*"It's just like if you say in Norway, the leaves will turn yellow in autumn. It's not inherent in you. The leaves are just yellow."*

The difference between inherent knowledge and yellow leaves was somewhat like your genetic pool and your culture. It is introduced, but it is there around you at all times and you grow to understand it. She said white psychologists at times tend to over-romanticise traditional healing as something different because they don't know about it, and would even go to an extent of wanting to train as a sangoma in order to be identified with doing what clients would regard as being important for them. LL on the other hand, acknowledged the differences of abilities, and would not wish to train as a sangoma because she was not called to be one. She also explained how the two forms of healing approach different parts of an individual: when clients consulted a sangoma, they went to deal with what could be causing them to be ill. And the cause related to witchcraft, they went in order to know who was bewitching them and how to deal with that situation. A therapist worked with the symptoms. For example with psychotic patients, a therapist addressed hallucinations in the western sense. Not as being caused by a neighbour, but as a chemical imbalance.

***“What can we salvage from western psychology?”***

HH turned the perspective around and said there has been a massive debate for twenty years in South Africa about the fact that the country had imported American ideas, British ideas and Freud with very little modification initially. He said that what people have done in the debates was to try and be critical; critique western views and European psychology, interrogate it on where it is neglecting contextual understanding, and the struggle has been how to reshape a psychology well suited to a context, but at the same time not “throw the baby out of the bathwater”; not reject all principles and knowledge. And the difficult question would be when to say “this knowledge is not applicable to Africa”:

*“It’s been a tremendous debate. Because at one point, there were the radical people who said; “well, kick it all out!” ...but then what have you got – you see? What models have you got? It’s like almost denying knowledge, to reject the whole of Western knowledge. Because with it you seem to almost have to reject the whole of Western science– so of course you can’t. So the issue is what is salvageable?”*

#### **4.4 Adjustments for a better suited psychotherapy in South Africa**

With regards to the reshaping of psychology, in, line with CC and HH’s responses, the therapists had no problems listing a wide range of challenges psychotherapy needs to address in order to become a more culturally applicable tool, but when asking them how they went about specifically making the appropriate adjustments and modifications, the answers became more vague, the therapists more off-point and the whole matter much more complicated.

***“I find myself improvising a lot”***

Initially, the responses given to this question were general formulations like “I adapt” or “I find myself improvising a lot”. What can one deduct from this way of answering? Is it fair to assume that there were more struggles and challenges than ways of bridging them? One of my assumptions when entering into this exploration was that therapists working in a multicultural setting such as South Africa would be able to provide *answers*. Contrary to my expectations, I found that they struggled just as much as any therapist in finding their culture specific way. There were differences of opinion regarding how to modify, which challenges to address and what is important in cross-cultural work. One finding, or underlying issue, was that it seemed as if there was not much communication around how to best modify a model to make it appropriate for the South African context. Some of the therapists spoke of a fear of sharing their interventions if they were not conventional ones, and the outcome of such a fear in the profession would be that no dialogue existed to draw from, and that it would be difficult to move forward by means of each other’s knowledge.

### ***The silent therapy room***

One of the aims of the exploration was to find out more about interactions behind the closed doors of cross-cultural therapy rooms. Acknowledging the fact that therapist-patient confidentiality is important and necessary to facilitate security and trust and building solid alliances, I still wondered if this could not also be used as an excuse to silence a certain discourse on how to develop a cross-culturally adequate psychotherapy. This curiosity, I found, was not mine alone. GG saw the silent therapy rooms as a major challenge. She said she often wondered what people actually do in the room with the patient. She believed there was a fear in forums like group supervisions to actually open these doors, even to each other as professionals, exposing and openly talking about what exactly was being done, discussing concrete interventions, and said “we are afraid of each other”. She illustrated this with a personal experience:

*“I remember talking to my partner who is also a psychotherapist with twenty years experience, and I’m writing notes from one of my sessions and he says “ach man, you know, everybody reconstructs their notes” and I say “yeah, well, I probably **do** reconstruct them, but I need to track the session as it happens” and he says “nobody does that” ...so I’m sitting there thinking wow! So what **do** people do in their rooms????”*

She also pointed out a lack of robust theories and a publishing of papers around cross-cultural work, particularly focusing on controversial adjustments to theory informed interventions

### ***To understand the client’s worldview***

BB initially said he “established where the clients were at”, or what their expectations were, and moved on from there. Hence, if clients came because they wanted specific advice on something then he would “work with them around that”. I asked more specifically about those

situations. BB said he had an international upbringing allowing him to adapt, and I queried as to whether he was aware of what tools he was using within himself to bring about that adaptation. He responded that he had never thought of it that way, but that what he attempted was to understand the client's worldview and what a particular thing or issue means to them, and subsequently explore that.

LL was the therapist who said she improvised. She argued that over the years, she had become so much used to improvising that she had almost developed her own approach to working within the cultures that she met. When asking her how she went about doing these adjustments, the content of the improvising, she responded by saying she felt like she was answering the same questions over and over again. I queried more directly and asked what the improvisation or her own technique implied; what specifically it was that she did. She responded that the way she would attend to people, differed from the way she had been taught to attend to people. She gave an example of working with the extended family which I found to be more a contextual factor, and explored the topic further, asking about the treatment of individual clients. She responded that this would depend on the type of African client. People were becoming more and more westernised and individual therapy among the African elite was becoming the *same* as in the west. LL said that her practice was in the city, giving no culture related challenges, working in the rural areas, however, there would definitely be. She said that from her knowledge of literature in the African context you would expect people to for example somaticise instead of presenting emotional problems. However, she said that in her urban setting it was much less pronounced than one might think.

HH said that cultural understanding of practices is a complex question and made the same distinction. Clients in rural areas felt there was a big cultural divide, and the therapists would facilitate local cultural practices for healing and investigate how distress might be construed there. But in an urban setting, he described the situation to be different:

*“Black people who are living in the city who are of African descent and have African language, for example a guy works at BP as an accounts executive, well, I think it's a very different way or mode of engagement, because I think that he is understanding his differentness to a rural guy who might invoke indigenous cultural healing practices whereas this fellow may not.”*

Michalopoulos (2001) interviewed therapists in one of the rural areas of South Africa, the Limpopo province. Her findings also reflected this divide, where therapists working with psychotherapy were the ones providing the “alternative medicine”.

### ***“I don't see colour”***

One of the difficult things in South Africa was that therapists were scared to say that they did not understand, because professionals often felt guilty about not understanding. As a

consequence of apartheid, people were generally very aware of the political context. FF said South Africans come from a racist tradition and a danger would be trying to overadjust, be overly sensitive and pretending to know things when you did not. Antjie Krog (1998) described the collective white guilt she believed resulted from the fact that white leaders kept denying their guilt and provided no ways for whites in South Africa to work through their collective shame. In psychotherapy, this can be seen in therapists trying to make modifications, but instead not addressing the issues. FF said:

*“South Africans generally are **acutely** politically aware, and it can be very crippling; people are scared to identify somebody by something obvious, you know, you’ll say “that’s a black person”, and they’ll think “AAHH” like I said a terrible thing, or they’ll say, my favourite is “I don’t see colour”. Well, the only people who don’t see colour are **blind** and blind people can generally work out your race anyway.”*

***“Let me take you to practice”***

HH responded by saying: “let me take you to practice”. Working in a hospital setting and in clinics, he would often face having to analyse a client’s causal explanation. The adjustment would be to use that worldview rather than contradict it. If a client said it was sangomas or the ancestors speaking, saying “What messages might they be giving you? How can you respond to those?” HH explained that if he did not see local cultural practices as dangerous in any way, a good adjustment would be to endorse them and register a respect for that difference of healing. The modification lay in the balancing of working within the client’s worldview, but at the same time reserving the right to try and pose a more medical perspective on it if this were needed. Modification required balance and one would have to treat each case individually, as with any therapyprocess.

JJ also said the adjustment lay in the way she would see the person. She might work from a dynamic perspective and look at how earlier experiences impacted on current functioning, but without ignoring the racial or ethnic experiences of the person, or even their religious beliefs, as these allowed for adjustments in the application of psychotherapy.

***Understand the everyday-taken-for-granted***

KK suggested modifying psychotherapy to make it more culturally ownable, which was one of the challenges listed. He believed the way to do that was through understanding “the everyday taken-for-granted”, what he believed to be an essential phrase. We all grow up to understand what we are feeling and where it comes from. In the case of understanding distress or illness, a child would learn this through stories told by the family about illness. How such states were labelled would define how a child grew up to see them, so for therapists such understanding would make for an important adjustment.

***Humility***

KK also suggested modifying by assisting the psychological mindedness of the client. He did not make any distinction regarding race, but said that some people were not suitable for psychotherapy whether western or otherwise, because they were not psychologically minded. GG argued it was important to maintain focus on the universally human. The term psychologically minded she found jarring, as it is often applied to a group which is predominantly not white. That they did not accept the interpretations made by therapists trained in western psychotherapy did not mean they were not psychologically minded. GG said it might rather be therapists' own fear or lack of understanding that made therapy unsuccessful:

*"People can talk about certain groups that are not suitable for therapy and I'm thinking how do you make that judgement? Didn't you say that Western models are not suitable for working? When I was in my first year of training we were told that we should be careful of Western models and applying them in the context that you're in –and I'm like: "who makes that decision?" You impose **every** other Western thing on African people, we train in your language. And then they say therapy is not appropriate because it's what; it's imposing on???? Why don't you just bring it up, offer it and see?"*

The debate around psychological mindedness goes far beyond the borders of South Africa and relates to the question of psychotherapy's applicability. Are there clients who are not treatable by the psychotherapeutic model? And why is that so? If one assumes a psychic unity, one would then have to readdress the model rather than disregarding certain people as "untreatable" or "not psychologically minded".

KK, addressing the issue from this angle, shared GG's concern:

*"What can happen quite often, certainly with more interpretive psychodynamic approaches, is that there's the risk that somebody from another cultural community does not demonstrate the sorts of therapeutic performance, if I can use a dramaturgical metaphor, you would expect."*

Then therapists interpret the clients' behaviour using their own psychological lens and training, and perhaps incorrectly so. KK gave the example of people arriving late for sessions. In psychodynamic work this is considered to be of importance, but sometimes time means something different coming from another worldview. The cross-cultural therapist then has to decipher: is this resistance, passive aggressive behaviour or something completely different? KK argued that therapists need to reflect on such issues, and that above all retain a sense of humility. GG also felt therapists need to be more connected to their own weaknesses:

*"Of course we are experts at what we do, but maybe a bit more **humility**...yes, for me that feels a bit more healthy; to have some humility about yourself and in relation to the client, that this client knows herself better than you ever will."*

***"I think what I do is I draw on my own cultural background"***

KK acknowledged that there might be situations where his personal background might be a limitation. He said that in some instances, he would want to understand the extent to which the client held other frames of understanding to his and the degree to which those were

important in his world. And if they were, he reflected that he would not be able to deal with them very easily, and might even suggest the client see somebody who understands that frame of reference better than he does. He said:

*“I’ve done that in my time, I’ve referred people to traditional healers – spiritual healers, if they’ve felt that’s what they want. And particularly where the sorts of things that **I** do...just don’t have the same meaning to them as something else.”*

Conversely, GG responded that her way of adjusting was exactly that, to draw on her own cultural background. She grew up in a township which gave her the advantage of knowing the dynamics of these communities. Sometimes therapy involved adjusting the model to suit the circumstances. She gave an example of one of the difficulties in therapy; the psychotherapeutic frame. GG explained that the city she worked in did not have many successful African black women who could serve as role models for clients. Sometimes work related racism would be an issue in therapy and GG described a client attacking her, asking “what have you black women been *doing* all this time? I’m walking around and these men say all these things to me”. The modification to conventional dynamic therapy was seeing past the dynamic meaning of it, and seeing that this client required GG to make herself available as a role model. She had to weigh that against the western model of avoiding self disclosure and decided that the client was only 23 years old and needed to know that there were black women who survived and who went through the same abuse. GG said she made whatever adjustments needed, in general evaluating adjustments case by case. To her this was how therapy should be, she explained:

*“Because you can’t just prescribe and then say I’m going to stick with this come hell or high water. You make decisions based on who the client is, what they need. So I make myself available sometimes as their peer and I’m fine with it...of course my husband is a white male therapist and in that case he said “You did **what**???” and I thought “Fine, if there’s any damage to the relationship because of that self-disclosure, we’ll **repair** it”. That’s how therapy is – we’ll work through it in the room. I wanted to make myself available because I did not know any other women that I could kind of link her up with who’d serve that function.”*

***“What you do with it afterwards is often confusing”***

DD addressed the fact that there were different phases of a therapeutic process and some can be more challenging than others. She said if there was a belief system she did not understand, she would be genuinely interested in what it meant. What one did with the understanding afterwards, however, could be confusing. This phase in a therapy was about the actual work therapist and client did together, where one had to bridge the differences. HH spoke about the dialogue between the African worldview and western psychotherapy, about moving between the two worlds. He said he would not like to impose his worldview, but might reserve his own take on the issue. DD on the other hand said she might be quite upfront with the client and say: “from the model I’m working in, I might explain it like this, but you are saying you



might understand it differently. What do you think about my explanation, as compared to yours?” Another issue was being upfront about what therapy is. DD and KK believed that there was an assumption that people understand what they are signing up for when they seek psychotherapy, and that they understand what she called “the bizarre relationship” between a therapist and a client. They thought it to be an unfair assumption. DD drew a parallel to an appointment with a medical specialist. As a patient you might not understand why the specialist wants to take blood, so you ask. DD thought that similarly, therapists should be more transparent about what was underpinning a question, for example “Did you breastfeed the baby”? which would have value underpinnings about attachment theory, assuming there is a “right way” to form healthy attachments. She said:

*“I’ve got a great example, it’s a funny story and I always tell it to students – a family neighbour of mine went to see a therapist and he was completely unfamiliar with therapy, he comes from the businessworld. And every time there was a break coming up in therapy, the therapist would ask how he’d feel about the break. And when they’d come back: “how was the break for you?” and finally this neighbour said to me: “does the therapist have a crush on me or what’s the problem that she keeps asking me if I’m OK and she wants to know if I missed her?” And I thought it was a wonderful example of a therapist going very traditionally along, you know: “there’s going to be a break and that’s going to mean something psychodynamically”, and this man thinking “what’s wrong with this woman, I mean this is absurd behaviour, has she got a crush on me?” (Laughs) But it’s a lovely example of the assumptions we have.”*

#### **4.5 A therapeutic meeting that transcends culture? The prospect of Thirdness.**

The core of my investigation was whether it was possible to lift a cross-cultural therapeutic meeting to a metalevel with mutual recognition, and in that space, find healing. Jessica Benjamin describes her view of thirdness as a quality or experience of intersubjective relatedness, something equivalent to an internal mental space shared by two. Gerson (2004) argues that the third transcends individualities. I have investigated if it can transcend culture. Benjamin described a “shared third”, an opportunity to experience mutual recognition, something vital in cross-cultural work. Many of my informants expressed the view that understanding had been one-directional in South Africa. My research aim was to answer the overarching question of whether it is possible to create the concept of thirdness in an intercultural or cross-cultural therapy. This question revealed my positioning and theoretical approach as a therapist. Within therapytheory, the question could be said to be psychodynamic or even psychoanalytic in orientation. I also placed myself within the framework of Sam’s (2006) perspectives on psychological inquiry. The question was asked from a universalist position, my assumption being that there existed a psychic unity, but that culture modified the manifestations of human behaviour. In wording the questions the way I did, however, I intentionally left these two aspects open, giving each therapist the opportunity

to take his or her own stance. Some of my informants flat out disagreed with me. Others disagreed on the way to get to such a space. Some of them shared my conviction and some regarded it as an ideal towards which we should stretch.

I found that in responding to these questions, many of the therapists actually spoke within the framework of psychodynamic theory. Some of them had done so throughout the sessions, and had, like GG, explicitly defined themselves as psychodynamically oriented in their work. However, when responding to the two last questions, some of the ones who had responded more neutrally, also applied psychodynamic concepts and framework to describe their work. Whether this was a consequence of the wording, or a result of the fact that therapist training in South Africa has a psychodynamic orientation or other factors is hard to say.

***“A pie in the sky”***

CC completely rejected the idea. He said he thought it a “very bourgeois thing” to suggest that we “all just forget our differences and connect as humans” and compared it to white South Africans telling black South Africans “let’s just forget about race and just love each other”. He said that to him, it seemed to be “a pie in the sky” and argued that there existed a power dynamic between a therapist and a client that was exacerbated if the therapist was white and the client black. In CC’s opinion, those kinds of powerdynamics inevitably entered into a therapy. He therefore thought it naïve to assume one can disregard differences and connect at a human level. He said a universal overarching law or idea might be less useful than trying to connect to the person in the here and now of therapeutic context.

***“I guess there can be moments of profound connection, but I think they’re moments”***

DD puzzled over what exactly was constructed and co-constructed in therapy, and said she had no answer to the question. She said she was not entirely sure what goes on in a moment when people are connecting. Reflecting on it, she concluded that she believed there could be moments of profound connection between people where something is recognised may outweigh difference or diversity at that particular point. But she stressed that she thought they were moments. She said she did not think one could build a therapy on such moments, that you build a therapy just as much on the moments of difference. The way DD described these moments, was as moments where there was a sense of recognition. This was in accordance with Benjamin’s thinking, but also brings to mind Daniel Stern’s concept of “moments of meeting” in therapy. Maybe another way to look at moments of meeting could be to see them as an entrance point into thirdness, a moment of connection that leads to recognition and a shared space of understanding?

***“I believe that there is a common humanity”***

JJ said experiencing distress was a commonality and believed one could identify on that emotional level with a client, thus making creation of a sense of identification possible. This sense of identification I compared to the concept of mutual recognition that Benjamin (2004) described. BB also believed the creation of a sense of identification possible, because he believed there is a common humanity. The way to go about this would be to discuss it openly in therapy, thus creating a space for clients to feel safe to express their feelings. He said the commonality or the common identity in a South African context, would be along racial lines, dealing with the hurts of the past, hearing voices that were not heard before. The therapeutic aspect would be that these hurts would be shared in transference, the therapist working towards identification and commonality through the counter-transference. To be able to do this, BB said, one needed to be brave enough to confront the reality of the differences. This is also in line with Benjamin's idea of creating thirdness through negotiating differences and connecting.

#### ***Attributing blame to the self***

FF reflected that finding a sense of identification requires something both from the psychotherapist and from the client; a recognition that there are difficulties. In accordance with Benjamin's idea of surrendering to the principle of reciprocal influence in interaction, FF believed that the minute you recognise difficulties and differences, they half disappear. FF said that he mistrusted professional colleagues who said "it's never an issue for me", as it had certainly been an issue for him. He said he shared the wish of many South African therapists to be able to say that he was post-racist. Admitting that this was not the case, however, would not make one "a bad person" or refrain one from trying, he said, touching on Benjamin's description of the possible consequence of complementary relations where therapists would be in danger of attributing blame to the self, thinking that one is "bad" for having caused the client pain or suffering. Her resolution was to accept a necessary asymmetry while still maintaining mutual recognition. Sharing this view, FF said he believed therapists needed to be comfortable with their own race.

#### ***"It's about hearing in a number of different ways"***

Being asked if one could create a space for healing that transcends culture, FF did believe it was possible. Reflecting on how one would go about it; walking into a room as a person, with everything that comes along, FF said it would be difficult partly because one risked imposing one's own issues on the client in the attempt to be culturally sensitive. He outlined two kinds of dangers; saying "I don't see any of this" or the therapist foisting his own consciousness about culture on somebody for whom it was not that salient. A way of avoiding these dangers

would be by hearing in a number of different ways, which FF believed was what good psychotherapy was at all times; hearing multiple meanings and being alert to a potential meaning. And also being alert to the extent to which one wished it were not the meaning. He believed this to be particularly salient to South Africans. He said he wished he did not have to think about race all the time; that other people were not sore about it, that he himself were not sore about it and that he did not feel guilty about it. However, he found himself very clumsily raise these issues in therapy, discovering that at times, even when present in the material, it did not feel appropriate for the client to address it.

### ***“The shadows of apartheid”***

HH compared cross-cultural therapy in South Africa to a minefield due to the shadows of apartheid and its race issues. Creating a sense of identification was not a taken for granted and might not happen. He asked some pertinent questions: do people feel understood by a white therapist? Do white people feel understood by a black therapist? He explained that one of the shadows of apartheid was that white people refused to see black therapists. They would either think they were not culturally understood or they denigrated the person as lacking understanding or as being stupid. He said:

*“I remember once supervising a black student, and the coloured clients don’t want to see her because she’s African. They want to see the **white** student or the coloured student. They don’t want to see the black person because there’s denigration: the black person’s got to be “stupid”. See the racism is a product of apartheid across so called groupings, is not just a white-black thing.”*

He believed these paradoxes to be caused by misassumptions that were legacies of apartheid. Arriving at this point in his reflections, FF asked “Can a bridge be made?” He said he believed a bridge could be made and it could be a very deep bridge. The sense of identification could be created, but it was not something to be assumed at the outset, but arrived at through therapeutic work.

Having talked about self disclosure and making oneself available to clients, GG said that she did not make interventions unthinkingly, and found it a challenge thinking about how to make the best adjustments. For instance self disclosure: did it serve a particular therapeutic purpose? And when a client spoke of racism, the challenge would be deciding what to address: the overt racism or issues over and above the racism, focusing on early relationships and the templates that were set there. She expressed the opinion that race got layered on a variety of things that existed in other forms elsewhere in the world, like whatever inadequacies people might have, for black South Africans they got layered with race and coloured with not being good enough because of being black.

GG found it difficult creating thirdness with white clients because of the shadows of apartheid:

*"I've struggled with white clients. Actually, as I said, I do not want to see them. I have had them in the past and it's never worked out, partly because I almost feel like I'm being **assessed**. And it might be something that the client does, but maybe also because of my own dynamics of having grown up as not good enough. It's something that I don't like talking about. My mom when I was growing up, said "don't **disgrace** me in front of the white people". So that's a thread throughout my life as black –I won't disgrace my parents, especially with white people. And my mum thinks white people are clean, actually, most if you are very **untidy**. Your houses are clean because black women are cleaning your houses. So I sit there in front of the client and there are alternative feelings of anger and feeling very...kind of **undermined** and feeling like I'm never going to be good enough. "I'll never understand what this goddess is bringing because I'm not good enough and she's much brighter than I am" and that's not a great thing for a therapist to be bringing. I just feel....it's just too much actually in addition to having to focus on what the person is bringing, to be constantly battling these feelings of inferiority and I've tried it and I just – I don't want to do it. For me at least, I found if I can exclude that particular confounding variable, it just makes my life much easier...not easier, but more bearable.*

GG still said she believed it was possible to create a sense of identification, considering the fact that as human beings, we must share commonalities. But she cautioned against the pendulum swinging to the opposite extreme, where one would assume no difference when there was. There would be differences that one needed to accept, entailing the understanding of what it felt like to be different. She believed that both therapist and client, even when from different cultures, would have had points where they had been the other. She believed one could find a certain kind of vulnerability as a therapist and come to terms with the fact of not being perfect or the ideal, and just understand oneself, both as a human being and as a therapist. When understanding that being human comes with vulnerabilities, there were points where one can form identifications or connections with a client. GG related the question to her personal struggles. She argued that based on her other responses around white clients, it had become evident that it was something she shied away from. She said:

*"Probably on a deep level I might not believe it...on some level, say on an academic level maybe I kind of believe it. I struggle with difference in my work, with colleagues in this environment that I'm in and I just find it incredibly hard."*

She also confided that being married to a white man, while there were a lot of commonalities, there would be instances where she would feel like not wanting to deal with white people. She revealed that at the time of the interview, personally, she was at a point where socialising with her husband's friends was tiring for her due to the fact that they were all Jewish, white and middle class. She explained that at that point in her life, she was tired of being the different one:

*"I have moments when I'm sick and tired of white people. I get sick and tired of their arrogance –I get sick and tired of the way that they can be **completely** wrong and then be **so** confident in their wrongness that a person can sometimes be convinced that they are right. I just get tired –*

*it's good that some people have that level of self-confidence, but **boy**, it's **tiring** because in a sense it sort of silences debate, you know, it's like this is the truth."*

She explained that part of her difficulty with assimilation related to the fact that it worked only one way, it was not mutual. In her position, it was not about the other wanting to come into her world, understanding and interacting on her terms, rather, she would have to shift. She concluded by saying that it was her wish that there be that point of connection transcending culture, but that the point she was at in her personal life made it difficult to believe at some levels.

#### **4.5.2 How to create thirdness in cross-cultural therapy**

As mentioned earlier, Benjamin (2004) cited Cornell in saying that one of Ubuntu's meanings was "I'll go first", an acceptance of responsibility and initiation of change. Addressed by Benjamin, "going first" also entailed that acceptance of responsibility, even when it might not be yours. It is "being the bigger person" or, in accordance to Ubuntu philosophy, acknowledging that one cannot exist unless recognising the humanness of the other, and thus taking the first step. This was, in essence, what Gobodo-Madikizela (2003) did during her time of interviewing Eugene de Kock<sup>12</sup>. She took the first step in acknowledging responsibility, though it was not hers, and in recognising his need to regain his humanness in order to fully accept responsibility for his own actions, and be reinstated to the human community. However, though in-depth interviews, they were not therapy. Did my informants believe thirdness would be created by them "going first" or did they believe it was attained in other ways?

#### **Breakdown and repair**

GG was the therapist who said earlier that any damages were repaired within the relationship. She said that it was important as a therapist to allow oneself to take risks in what one does with patient utilising the framework of psychodynamic therapy of breakdown and repair within the relationship:

*"I don't think it can be hugely damaging, otherwise one would know – the client would have run away long time ago. Because this is what it's about – it's about a relationship and being open to **learning** from the person and being corrected by the person."*

GG responded in accordance with Benjamin's (2004) view of a therapy as a continuous breakdown and repair, and that it is through the ameliorating action of taking responsibility and mutual recognition one opens for the potential space of thirdness.

***"That's a hell of a question."***

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<sup>12</sup> See section on Ubuntu

KK believed that, profoundly, there was a universal human condition; that regardless of origin, certain events in life are common to humans: family trouble, children that challenge boundaries, relationship difficulties. KK said they are not difficult to identify when subtracting the particular manifestation of the issue; human emotions are pan-cultural. KK would be in accordance with the universalist position and what he supported was the existence of a psychic unity. KK believed that cross-cultural work could play a devil's role in escalating difference and if one gets too hung up on culture and forgets universality, one risks forgetting the common human condition. To his mind, while working with cultural issues, one should always ask the question "what is the same?" The challenge would be the times where the client's mode of conversation, explanation and delivery, was very remote to the therapist's. He admitted that he would struggle with that. But he believed that if one cannot find common ground as a therapist, one has "lost the plot". He also argued that without common ground, one has no ability to empathise, which he considered to be a fundamental part of therapy. Even if one did not reach a sense of understanding to the same extent as with a client from the same cultural background, one could approach issues and share them.

***"Differences in skin are just minor adaptations to the essential quality of humans"***

HH said the answer to whether one could create a space for healing transcending culture was yes and no. Yes in the sense that he believed in an essential humanness. He said the beauty of genetics and the genome projects, was they showed we were all related. Differences in skin and features were all just minor adaptations to the essential quality of humans. HH said that though some people are more expressive than others, or display emotion differently, we have the same range of emotional life. However, he did not believe one can sidestep everything we are as individuals and immediately connect at a universal level, though he believed it exists. He told me he remembered trying to write a paper related to the development of intersubjectivity in psychotherapy. His concept for the paper was something he called "interculturality" that one needed to address in therapy. Finding the intercultural space. He illustrated it:

*"Let's say a black person says: 'look, I'm really not sure if you'll be able to understand me'. If I was totally universalist, I would be naïve and say: 'I'm sure I can, we're both humans'. But another response would be to say: 'You know? I'm not sure if I can....let's try. Let's just see if we can talk about it and let's see if we can reach an understanding of whether I can.'"*

He underlined that one could never make an assumption about universality. Therapists had to grapple with differences and recognise them. Difference had to be interrogated, thought about, fed back to the client, and as a therapist one had to explore how it influenced understanding. Acknowledging difference, HH believed, would take up a different, bi-directional dialogue,

and then one might reach a place where one could say “We understand that difference that divides us, but it doesn’t overwhelm us” HH believed talking about the difference was a point of connection and through which there was a working edge to obtaining healing.

***“You still go there as you”***

When asked if one could find each other at a metalevel, JJ gave an affirmative answer:

*“I think you can, and maybe, in a therapeutic context when you find each other at that level where you can actually **connect**, maybe issues of culture and difference aren’t pertinent anymore, but they’re still **there**. You might not choose to address them because your client’s need is a particular thing in that point in time, but you don’t just drop who you **are**.”*

LL responded in a similar fashion and said that one cannot separate culture, ethnicity and therapy, because you would bring your whole self to that human or universal level. And the way client and therapist would interact there, was infused by culture. LL believed one could not do therapy without bringing in culture. However, the magnitude of culture, the way in which the therapist would be applying it within the human interaction, would differ according to the problem being presented and according to the client-therapist relation. LL concluded that one could meet at a human level, but with the culture very much intact, and the magnitude, or degrees of how much culture would be brought in at that human level would vary, but there would always be some, and it would increase or decrease during a therapy.

***“In that very intimate one-on-one space, the psychotherapeutic model holds”***

What the therapists were implying in these responses, KK touched on at an earlier point: given the time and the framework needed to apply psychotherapy, one could create identification starting from quite different perspectives, or “opposite poles” as KK put it. DD described a case where she saw a client very dissimilar in cultural background to herself, and where she suddenly found that the challenges were not so defining for the therapy anymore:

*“I was thinking of work I did with a black African woman with a profoundly traumatic history of abuse, and a dominant political struggle. What was interesting was that in that very intimate therapeutic space the issues we were dealing with were not very different from what anyone else would have if they had had that kind of history. And because we had the time to build a relationship, the race issues and the different belief systems are a little less foregrounded because we’re working intimately together regularly. So, in that very intimate one-on-one space, the psychotherapeutic model holds, I think, if you have the time to build the kind of relationship the psychotherapeutic model requires. The possibility of building that relationship and the possibility of ongoing contact is a question in this context, but that has to do with results – whether people have the time and the money, and **access** to come in to see someone regularly in **their** therapy room, as opposed to you going somewhere to see them. But given that I think that sometimes it’s not that different.”*

## **5. DISCUSSION**

The purpose of this study was to address four research questions on therapeutic work and African culture, informing the investigation of the therapeutic meeting in a South African



context. I also wanted to investigate what adjustments South African therapists made in order to create a psychotherapy better suited for the South African context. I proposed the notion or philosophy of Ubuntu as a way of providing an African aspect to psychotherapy.

I entered the investigation looking for unifying or universal elements, a psychic unity that could facilitate healing in the context of diversity, but assuming that there were profound challenges to be overcome. Psychological and anthropological studies had shown that psychotherapy was struggling to gain ground in Africa alongside the different forms of traditional healing and that South Africa, with its multiethnic society and apartheid history provided specific challenges for the field of psychotherapy. My assumptions were, in general, supported by my data, while also providing some new perspectives.

As demonstrated in this study, therapists meet an array of challenges in their everyday work. My informants described struggles on two levels: the one, overwhelming area was challenges related to poverty. I saw these to be struggles to the ability to provide therapy. One cannot do psychotherapeutic work if there is no meeting. One of my informants said they had no “one-session-fix-all” model, and many of the therapists questioned the role of psychotherapy in South Africa, illuminating what it actually means to “struggle with poverty” as a therapist. The consequence of these challenges could be that therapists often would not see a patient more than once. This is de facto, then, a form of one session therapy. As a therapist one would need to reflect on this. How should one address it? Would one disregard psychotherapeutic protocol in an effort to send the client home with some small form of healing elements, or rather conclude that with such lack of framework any form of psychotherapy is impossible? One informant wanted more creativity in therapy. These are also issues around which to think creatively.

The lack of culture appropriate theory was highlighted. Most of the informants spoke of the African sense of interconnectedness in this regard, and how to bring it together with psychotherapeutic thinking, one of the informants even explicitly mentioned Ubuntu as a possible basis for the development of such theory. There was another aspect to this issue: Entering into this exploration, I believed literature addressing African psychotherapy was scarce. My informants, however, said that while there was a want for culture appropriate theory, such literature existed. One of my informants said that “most of what is written says that nothing has been written”. If western countries like Norway are to learn anything about how to create space for successful therapies with African clients, they would be aided considerably by a template to work from. Why is such a template not made available when it exists? It seems as if this literature is Africa’s best kept secret at times. Even while in South

Africa, bookstores and libraries often told me that they could not help me. After returning to Norway, the access became non-existent. Even books with known ISBN numbers somehow could not be traced. In my opinion, this creates a *knowledge divide* between Africa and the west, where knowledge about Africa stays in Africa. One informant blatantly said this literature would not be accessible in Norway. One outcome of this could be that the continent of Africa slips off the research map in the west. It could also cause researchers to duplicate each other's work. Consequently one would never move past a stage of researching topics "never" researched before.

Moving the exploration in to the therapeutic meeting, my informants described more culturally related challenges. The African worldview was discussed and the relation to traditional healing. At the outset, I explored the notion of creating an African integrative model, like the concept of Ubuntu therapy. Most of the therapists were negative to such a prospect, opting for the co-existence of psychotherapy and traditional healing as they are parallel models for healing. The investigation also changed my own opinion on the matter. I became more inclined towards maintaining psychotherapy in its purer form. Keeping psychotherapy as a separate discipline is dissimilar to saying that psychotherapists cannot be informed by other traditions for healing, however. To close one's mind to influence is not a viable way to bring about change.

Further findings showed that while able to list a long line of challenges, when asked how to address these challenges, what specific modifications they made, the therapists struggled to respond, often openly expressing their difficulties. One could ask why this was the case. One possible explanation would be that it is difficult to see oneself from the outside. Another prospect would be that there is a fear of sharing such modifications for different reasons. One of my informants expressed such a view, also questioning the silence of therapyrooms in South Africa. Though all pertinent ideas, another explanation would be that informants were utilising the interviewsessions to reflect on their therapeutic challenges and insecurities, giving a glimpse of therapists' experiences of the therapeutic meeting. Many of the responses supported such an explanation.

The therapists also addressed specific challenges related to the legacy of apartheid. There were challenges to what clients brought to therapy in this regard, like the hypervigilance of the oppressed and white clients' refusal to see black therapists. Therapists also carried it in themselves. They addressed the black inferiority complex and the collective white guilt, resulting in a feeling of inadequacy in relation to black clients. The meetings between myself and the therapists were also important. Each interview left me with a certain sentiment which

could be traced back to the interaction during the interview. Some interviews were hard to conduct, where answers came slowly or with misunderstandings at every question and where I sensed a resistance to answering the questions at all, one of the interviews felt like a battlefield throughout. In others, there was flow and a mutual understanding and I left the session inspired and energised. I tried to analyse this, but found no good explanations, maybe it was as with therapy: the co-created reality of individuals? Some interviews almost felt like providing therapy. Berry et al (2002) discuss the thin line between an in-depth research interview and a therapy session which I feel is a valid discussion.

Arriving at the end of my exploration, wanting to make an ingenious conclusion, I was left with this: I believe there is no such thing as a perfect cross-cultural therapist. Rather, there are multiple perfect cross-cultural therapists, because there are multiple therapists with diverse cultural backgrounds. We each have to find our own way. What you bring in to a therapyroom is unique. I still believe, though, as I did initially, that Norway has much to learn from therapeutic meetings in a South African context, though there is, as HH put it: “no one book that prescribes it all”. There is just the engaging, the grappling, the continuous questioning which is also what helps us develop as therapists. This dissertation certainly does not describe it all, but it provides a glimpse of a working context I believe is relevant also in Norway in this globalisation era. I am still of the opinion that psychotherapy can be applied to people of different cultures. I believe some framework is essential, but that there are elements of it which can be bent to accommodate context, like the venue for therapeutic work. KK said he had therapy sessions in the hillside behind a university because it was necessary. One has to be open to the fact that different clients need different things, have the ability to, as GG put it, be creative. Psychotherapy is a dynamic discipline, developing according to the new challenges faced by psychotherapists.

I have addressed the seeming lack of communication, sharing and debate around what takes place in cross-cultural therapyrooms. At the end of this exploration, I feel the urgency for such debate even stronger. Why should we be scared of one another? Irvin D. Yalom in his book “Lying on the couch”, (1996) talks of the difficulties of being an artist without an audience, comparing psychotherapeutic work to a painter having to keep all his paintings hidden from the world. He claims psychotherapists work without an audience. Why not be each other’s audience? In closing, I would also like to express a fraction of all the ways in which this has been a humbling experience for me. This investigation has taught me that there are no shortcuts to finding the other in a therapy room. The therapeutic meeting holds aspects that remain a mystery to me.

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## **APPENDIX**

### **Appendix A: Interview Guide**

1. Do you see psychotherapy as a culturally determined tool for healing? Why/why not?
2. What do you see as a challenge with regards to applying psychotherapy in different cultural contexts?
3. Psychology might be said to be dominated by Western culture and standards. Has this influenced your work in any way? What do you think is not fitting in this cultural context? What is missing?
4. If you meet problems in applying Western theories/techniques in your practice, how do you go about to do the appropriate adjustment and modification?
5. Can you mention some difficulties or challenges you meet in your practice?
6. In your experience as a psychotherapist, has there ever been a situation where you found you had difficulties with a client of another cultural background than yourself, and what specifically were those difficulties?
7. What would you recommend therapists do in order to address such problems?
8. Is the challenge of cross-cultural counselling being adequately addressed in the training of clinical psychologists today?
9. How do traditional beliefs influence your work (if they do)? Do you sometimes use traditional African literature, traditional beliefs or traditional healers as guidance?
10. Are there any specific challenges with regards to African culture and the use of psychotherapy? If so, what are these challenges?
11. In your opinion, should clinicians incorporate traditional forms of healing into psychotherapy? Should clinicians be educated and trained in these forms of healing?
12. In what ways does your own cultural background affect your work as a psychologist/therapist?
13. South Africa has gone through a lot of changes the last years. How has this influenced you in your work as a psychologist?
14. How do you think psychology as a field can develop and be more appropriate for the South African context?
15. Is it possible for a sense of identification to be created between a therapist and a client with different cultural background, and if so, how?



16. Is it possible in a therapeutic meeting to interact on a universal human level, completely assimilating the culture and ethnicity of both therapist and patient thus creating a space of interaction that transcends culture and ethnicity? Why/why not

Here I actually started by writing completely disregarding, not assimilating. I think this is a complex question. Reversing it makes it a little different.

**Background questions:**

Where did you train?

When did you finish your training?

What kind of therapist training did you have?

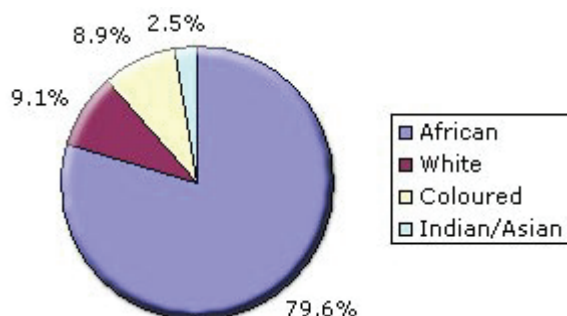
What populations have you been working with?

## Appendix B: Facts about South Africa:

South Africa is a nation of over 47-million people of diverse origins, cultures, languages and beliefs. According to the mid-2007 estimates from Statistics South Africa, the country's population stands at some 47.9-million, up from the census 2001 count of 44.8-million.

### South Africa's population by race:

Africans are in the majority at just over 38-million, making up 79.6% of the total population. The white population is estimated at 4.3-million (9.1%), the coloured population at 4.2-million (8.9%) and the Indian/Asian population at just short of 1.2-million (2.5%).



While more than three-quarters of South Africa's population is black African, this category is neither culturally nor linguistically homogenous.

### White, 'Coloured' and Asian South Africans

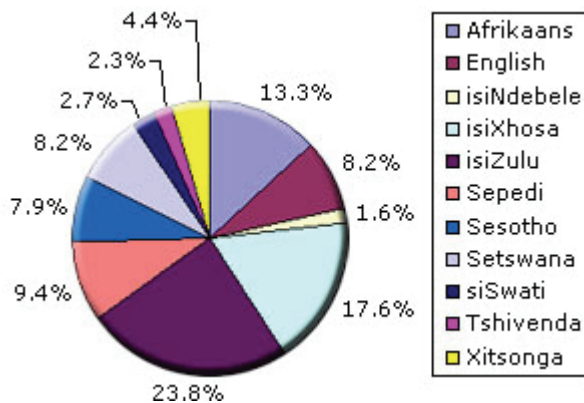
South Africa's white population descends largely from the colonial immigrants of the late 17th, 18th and 19th centuries - Dutch, German, French Huguenot and British. Linguistically it is divided into Afrikaans- and English-speaking groups, although many small communities that have immigrated over the last century retain the use of other languages. The label "coloured" is a contentious one, but still used for people of mixed race descended from slaves brought in from East and central Africa, the indigenous Khoisan who lived in the Cape at the time, indigenous Africans and whites. The majority speak Afrikaans. Khoisan is a term used to describe two separate groups, physically similar in being light-skinned and small in stature. There is much debate about the origins of the Khoisan - some scholars have suggested that they originated from Asia, some from North Africa. The view of the San, Bushmen or Khoikhoi has always been through European eyes - this is because Europeans have a long tradition of recording written history, and so it is easier for people to reference this information. During the Middle Ages, Africa was known as the Dark Continent (khoisan.org, 2008). The Khoi, who were called Hottentots by the Europeans, were pastoralists and were effectively annihilated; the San, called Bushmen by the Europeans, were hunter-gatherers. A small San population still lives in South Africa. The majority of South Africa's Asian population is Indian in origin, many of them descended from indentured workers brought to work on the sugar plantations of the eastern coastal area then known as Natal in the 19th century. They are largely English-speaking, although many also retain the languages of their origins. There is also a significant group of Chinese South Africans.

### Language:

There are 11 official languages in South Africa:

Afrikaans, English, isiNdebele, isiXhosa, isiZulu, Sepedi, Sesotho, Setswana, siSwati, Tshivenda and Xitsonga. Nine of the country's 11 official languages are African, reflecting a

variety of ethnic groupings which nonetheless have a great deal in common in terms of background, culture and descent.



Africans include the Nguni people, comprising the Zulu, Xhosa, Ndebele and Swazi; the Sotho-Tswana people, comprising the Southern, Northern and Western Sotho (Tswana); the Tsonga; and the Venda.

### Religions in South Africa

In terms of religious affiliation, about two-thirds of South Africans are Christian, mainly Protestant. They belong to a variety of churches, including many that combine Christian and traditional African beliefs. Many non-Christians espouse these traditional beliefs. Other significant religions are Islam, Hinduism and Judaism.